

**THE SIZE PARADOX: THE MEGA-MATERNITY  
UNIT AS A VECTOR FOR AUTHENTIC  
MIDWIFERY TO EMERGE**

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**Student Declaration**

I declare that the content of this assignment is all my own work. Where the work of others has been used to augment my assignment it has been referenced. This material has not been submitted for any other award

## **ABSTRACT**

Midwifery practice in Ireland has emerged from a system of care dominated by the biomedical model of childbirth. The aim of this study was to explore the experiences of labour ward midwives who are potentially complicit with this approach. This study reveals how midwives' environment impacts on their construction of childbirth.

The opening of a large new maternity hospital afforded the opportunity to see if the move to this setting would influence midwifery practice. A hermeneutic phenomenological approach was used based on the work of Heidegger and Gadamer. The study was undertaken in two phases, the first involved interviewing six labour ward midwives working in a busy obstetric led labour ward which was due to close. The findings revealed that midwives complied with the norms for the unit and did not take responsibility for the biomedical approach to care.

The second phase was undertaken twelve months after the opening of the hospital which was an amalgamation of three maternity units. Seventeen midwives were interviewed for this phase of the study. The move to the larger unit revealed a paradox for midwifery autonomy and enabled midwives to practice in new ways. The maternity service was delivered through a system that values detachment and an attempt at equal (not individualised) care under conditions of limited resources and constraints. This had resonance with Lipsky's and Foucault's work. A contrasting situation occurred within the individual labour rooms as the midwives worked in relative isolation, away from the general activity of the unit. This phase of data was framed in terms of Merleau-Ponty's four existentials. Midwives had opportunities to enact 'real midwifery' and normalise birth for women using a range of strategies rather than resorting to interventionist therapies. Midwives shared in the joy of achievement when positive births occurred. The paradox of this mega maternity unit enabled authentic midwifery to emerge.

The study provides an insight into the experience of labour ward midwives and how midwifery identities are revealed by the narratives they relate. It also highlights the complexity of contemporary maternity care in large centralised maternity units.

# Table of Contents

ACKNOWLEDGEMENTS .....	v
List of abbreviations .....	vi
CHAPTER 1 INTRODUCTION .....	1
SECTION 1 SETTING THE SCENE .....	7
CHAPTER 2 BACKGROUND .....	7
Introduction .....	7
2.1 Normal or technocratic birth: competing paradigms .....	8
2.2 Beliefs about birth .....	10
2.3 Midwives and the growth of technology .....	11
2.4 Midwives' contribution to maternity care .....	12
Conclusion.....	13
CHAPTER 3 MATERNITY CARE IN IRELAND .....	15
Introduction .....	15
3.1 Maternity service provision.....	15
3.2 Home Birth Services.....	17
3.3 Midwifery led units .....	18
3.4 Lourdes Hospital Report.....	19
3.5 Recent reports on maternity care .....	21
3.6 Women's views of the maternity services .....	21
3.7 Regulation of midwives.....	22
3.8 Midwifery practice within Irish maternity services.....	23
Conclusion.....	24
CHAPTER 4 METASYNTHESIS OF MIDWIVES' EXPERIENCE OF HOSPITAL PRACTICE.....	26
Introduction .....	26
4.1 Metasynthesis .....	26
4.2 Strategy.....	27
4.3 Researcher reflexivity.....	28
4.4 Scoping stage for the metasynthesis.....	29
4.5 Search questions .....	30
4.6 Final selection of studies .....	33
4.7 Appraisal of studies .....	35
4.8 Iteration of themes .....	35
4.9 Themes identified .....	37
4.9.1 Power and control.....	37
4.9.2 Compliance with cultural norms.....	39
4.9.3 Attempts to normalise birth in a hospital environment .....	41
4.10 Synthesis.....	42
4.11 Discussion.....	43
4.12 Limitations.....	47
Conclusion.....	47

CHAPTER 5 THEORETICAL PERSPECTIVE AND METHODOLOGY.....	49
Introduction .....	49
5.1 Competing paradigms in contemporary research .....	50
5.2 Post-positivism and its contribution to constructing evidence for health care .....	52
5.3 Theoretical approach .....	53
5.4 The representation of the researcher in qualitative research .....	54
5.5 Constructionism and hermeneutic phenomenology .....	55
5.6 Edmund Husserl (1859-1938) .....	56
5.7 Martin Heidegger (1889-1976).....	57
5.7.1 Hermeneutic Circle.....	60
5.8 Hans-Georg Gadamer (1900-2002).....	61
5.9 Utilising hermeneutics as a research approach.....	62
5.10 Gaining understanding through the analysis of interview data .....	64
5.11 Identification of pre-understandings.....	66
Conclusion.....	67
SECTION 2 FIRST STAGE OF DATA COLLECTION .....	69
CHAPTER 6 METHODS PHASE I.....	69
Introduction .....	69
6.1 Study design .....	69
6.2 Setting for Phase I .....	70
6.3 Ethical approval.....	71
6.4 Negotiating access .....	71
6.5 Sample Phase I .....	72
6.6 Data collection.....	73
6.7 Ethical considerations.....	74
6.8 Ethical issues in phenomenological research .....	76
6.9 Data management .....	77
6.10 Analysis .....	77
6.11 Trustworthiness of the data .....	79
Conclusion.....	80
CHAPTER 7 ‘CALM BEFORE THE STORM’ .....	81
Introduction .....	81
7.1 Consensus of care and compliance with norms.....	82
7.2 Powerless to initiate change .....	86
7.3 New life and nice work.....	88
7.4 Immanently contested space.....	90
7.5 Changing practice and learning new skills .....	95
7.6 Uncertainty ahead.....	96
Conclusion.....	98

SECTION 3 SECOND STAGE OF DATA COLLECTION .....	100
CHAPTER 8 METHODS.....	100
Introduction .....	100
8.1 Access to setting .....	100
8.2 Labour ward setting .....	101
8.3 The organisation of midwifery work .....	102
8.4 Sample Phase II .....	103
8.5 Data collection.....	104
8.6 Interviews Phase II .....	104
8.7 Data analysis.....	106
Conclusion .....	106
CHAPTER 9 INTRODUCTION TO FINDINGS.....	107
CHAPTER 10 THE STORM HITS .....	111
Introduction .....	111
10.1 Impending uncertainty .....	112
10.2 Battling the storm .....	113
10.3 Conquering the storm .....	114
10.4 Storm clears the decks .....	115
Conclusion .....	117
CHAPTER 11 WEATHERING THE STORM (BALANCING ALL NEEDS).....	119
Introduction .....	119
11.1 Going with the flow .....	120
11.2 Never ending swell .....	125
11.3 The epidural question .....	128
11.4 Contested priorities.....	131
11.5 Clearing the decks .....	134
Conclusion.....	135
CHAPTER 12 ANY PORT IN A STORM (FREEDOM AND VULNERABILITY) .....	137
Introduction .....	137
12.1 Island in the storm .....	138
12.2 Sink or swim.....	140
12.3 Cast on to the rocks .....	143
12.4 Your own lady in your own four walls.....	148
Conclusion .....	151
CHAPTER 13 IN THE EYE OF THE STORM (MIDWIVES' TERRITORY).....	153
13.1 Time and place - my space, my territory .....	153
13.2 Forming and strengthening bonds .....	156
13.3 Steering a course- the epidural question again .....	158
13.4 Spending time and wasting time - a basket of strategies.....	162
13.5 Breaking free .....	166
13.6 Protecting the space .....	168
13.7 Getting into the psyche .....	170
13.8 Labouring in the eye of the storm – sharing the beauty of birth .....	172
Conclusion.....	179

SECTION 4 THEORISING THE FINDINGS .....	182
CHAPTER 14 STREET LEVEL BUREAUCRATS WITH DAMAGED IDENTITIES .....	182
Introduction .....	182
14.1 Challenges for labour ward midwives in contemporary maternity care.....	183
14.2 Street Level Bureaucracy.....	186
14.3 Structures of power in contemporary maternity care .....	190
14.3.1 Before the move – under the gaze of the Panopticon .....	190
14.3.2 After the move – disruption of the Panopticon gaze .....	192
14.4 Damaged identities .....	193
Conclusion.....	197
CHAPTER 15 THE SIZE PARADOX AND AUTHENTIC MIDWIFERY .....	199
Introduction .....	199
15.1 Merleau-Ponty .....	201
15.2 The four existentials and the size paradox.....	205
15.2.1 Temporality - the lived time of midwives’ experience of birth.....	206
15.2.2 Relationality - the lived relationships of midwives’ experience of birth .....	211
15.2.3 Spatiality - the lived space of midwives’ experience of birth .....	216
15.2.4 Corporeality - the lived body of midwives’ experience of birth .....	221
Conclusion.....	226
CHAPTER 16 REFLEXIVITY CHAPTER.....	229
CHAPTER 17 EXPLAINING THE PARADOX – NORMAL RULES DON’T APPLY ....	233
Introduction .....	233
Recommendations .....	236
REFERENCES .....	239
Appendices .....	i
Appendix 1 Characteristics of included studies .....	ii
Appendix 2 Plan of labour wards for three hospitals .....	iv
Appendix 3 Ethical approval letters .....	vi
Appendix 4 Notice for midwives Phase I.....	xi
Appendix 5 Information for midwives Phase I .....	xii
Appendix 6 Consent form Phase I.....	xiii
Appendix 7 Biographical details of midwives interviewed .....	xiv
Appendix 8 Interview schedule Phase I .....	xxii
Appendix 9 Example of data coding .....	xxiii
Appendix 10 Information for midwives Phase II .....	xxiv
Appendix 11 Consent form Phase II .....	xxv
Appendix 12 Interview schedule Phase II .....	xxvi
List of Tables	
Table 1 Search strategy for metasynthesis .....	30
Table 2 Selection of studies.....	32
Table 3 Final exclusion of studies .....	34
Table 4 Iteration of themes and synthesis .....	36

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## List of abbreviations

AFI	Amniotic fluid index
ARM	Artificial rupture of membranes
CAQDAS	Computer-assisted analysis of qualitative data software
CMM	Clinical Midwife Manager
CREC	Clinical Research Ethics Committee
CTG	Cardiotocograph
EDD	Expected date of delivery
ER	Emergency Room
ESRI	Economic and Social Research Institute
FBS	Fetal blood sampling
FHEC	Faculty of Health Ethics Committee
HSE	Health Service Executive
I/V	Intravenous (infusion)
ICM	International Confederation of Midwives
IDDM	Insulin dependent diabetes mellitus
IUGR	Intra uterine growth restriction
KPMG	Klynveld Peat Marwick Goerdeler
NCT	National Childbirth Trust
NICE	National Institute of Clinical Excellence
OECD	Organisation for Economic Co-operation and Development
OP	Occipito posterior
PPH	Postpartum haemorrhage
TENS	Trans electrical nerve stimulation
WHO	World Health Organisation

## CHAPTER 1 INTRODUCTION

For contemporary midwives, childbirth is a complex territory between the requirements to provide individualised care and choice to women, to support normal birth, and to ensure that practice is based on the best available evidence. Midwives in hospital labour wards work in an environment where medication and technology are available to control and manage birth and to potentially provide women with a pain free labour. There is a debate about the value of normal or ‘intervention free’ (Downe 2008a) and there is evidence that inappropriate intervention can lead to problems for women and their babies (Tracy et al. 2007). There are global concerns about increasing caesarean section rates and the impact this has on both morbidity and mortality (Villar et al. 2006, MacDorman et al. 2008) and it has also been shown that larger units have a greater propensity for intervention in labour and a lower rate of spontaneous births (O’Connell et al. 2003). This is a particular concern in Ireland as there is the drive to centralise birth into large centres (Kennedy 2002a, Devane et al. 2007).

It is within this context that this study is being undertaken. The term ‘medicalisation of childbirth’ is widely used in contemporary literature in relation to the model of care which takes place in hospital where obstetricians determine the management of childbirth. This implies that the power in maternity care lies with the medical profession. Yet, in many parts of the world, midwives provide much of the care to labouring women but do not acknowledge the role that they play in the ‘medicalisation of childbirth’ (Anderson, 1999). They tend to place responsibility for this medicalisation on, obstetricians, ‘other midwives’ and even women themselves (Crabtree, 2004, Hyde and Roche Reid 2004).

This study was undertaken to examine this issue in depth. In particular, I sought to explore labour ward midwives’ construction of childbirth as they negotiate ways of facilitating birth in the risk adverse environment of the hospital labour ward. I was interested to know how midwifery practice is perceived, how innovations are adopted or resisted, and how birth practices are disseminated among midwives where intervention into childbirth is the norm. Of additional interest is how midwives facilitate birth and whether there are occasions where they perceive that they are

instrumental in normalising birth. In this way I hoped to explore with midwives the experience of midwifery in the context of their everyday practice and to ascertain the possibilities of a midwifery commitment to normalising birth in a large obstetric led hospital environment. This is the area of research that has not previously been investigated.

The context of the enquiry was a busy maternity hospital in Ireland which was due to close and merge services with two other units into a large new hospital. The number of births in this hospital was approximately 3,000 per year. This afforded the opportunity to explore with the labour ward midwives their experience of midwifery in their existing environment and to complete the study by interviewing midwives following the move to a larger unit which would be a very different environment for all staff. In this new setting, there were just fewer than 9,000 births in the first complete year following its opening and it is thus one of the largest maternity hospitals in Europe. I hoped that this would uncover the essential meaning of midwifery for these midwives, as they adopted or resisted new practices when they adjusted to their new setting. Would the change of environment impact on their perception and experience of labour ward midwifery practice?

This study was therefore undertaken in two phases. The first sought to ascertain the experience and established practices among the labour ward midwives in one of the hospitals due to close. The midwives were scheduled to transfer to a large newly built hospital one year later. Six midwives were interviewed for this phase of the study. They were asked what midwifery meant to them and about their experience in providing care for women in labour in what they themselves described as a medicalised environment.

The second phase was undertaken twelve months after the opening of the new hospital. Of particular interest in this phase of the study was if the midwives would adapt or innovate within their practice within this new and much larger setting. I encountered greater diversity in the experiences of the midwives during this phase of data collection and for this reason seventeen midwives were interviewed

This introduction provides an outline of the structure of the thesis.

## **Structure of the thesis**

Chapter 2 provides an introduction and background to the current debate about conventional hospital based maternity care, in particular how this impacts on childbearing women and the midwives who work in this environment.

Chapter 3 provides an account of the maternity service and midwifery practice in Ireland and sets the context for this study.

Chapter 4 consists of a metasynthesis of qualitative studies of midwives' experience of hospital practice. This was undertaken to systematically review the current work in this area and gain an understanding of midwives' discourse about hospital based midwifery. Power and control, compliance with cultural norms and attempting to provide 'real midwifery' for individual women emerged as a common experience of midwives throughout several countries. The synthesis highlighted issues that confront hospital based midwives who claim to be unable to practice autonomously due to various constraints on their practice. Midwives, blamed 'others' for the technocratic approach to maternity care but maintain that this receives support from some midwives and from women themselves who readily accept or expect intervention during the process of birth.

This chapter forms the framework to this present study as I wished to develop an understanding of the topic based on contemporary knowledge while avoiding a replication of previous work. The metasynthesis led me to question the meaning of midwifery experience of labour and birth. Rather than looking outwards at the constraints and barriers that midwives articulate, I decided to probe behind this and to explore midwives' beliefs and perceptions about birth, and what meaning these constructs have for the midwives themselves. For this reason, phenomenology was selected as an appropriate way to explore these issues. I hoped to move away from an acceptance of compliance or guilt to probe the concepts of authenticity of the meaning of midwifery practice as it applies to labour ward midwives. I hoped that this would lead to an understanding of the lived experiences of midwives and the factors which may enable them to provide 'real midwifery' for individual women and support normality in childbirth.

Chapter 5 provides the theoretical perspective and methodology selected to undertake the study along with a justification for selecting phenomenology as the approach. Drawing principally on the work of Heidegger and Gadamer, phenomenology provided an appropriate theoretical and practical framework for understanding the practice of labour ward midwives that incorporates the context and individual experiences of participants.

In Chapter 6 the methods and context the study are detailed. As stated, the study was undertaken in two phases, the first involved interviews with six labour ward midwives who worked in a maternity hospital which was due to close. This chapter largely focuses on the methods for Phase I but to avoid repetition, issues relevant to both phases are detailed here.

Chapter 7 provides an account of the findings from Phase I which largely resonate with the findings of the metasynthesis. A consensus of care existed whereby midwives complied with the norms of practice for the unit or felt powerless to effect change. The space for birth was immanently contested in that there was an expectation that midwives or doctors could enter the labour room and potentially interfere with the midwife's care. This perception was ever-present. Despite this, there was a desire among midwives towards to normalise birth yet they worked in an environment where normal birth most often occurred by chance.

The new hospital opened several months after the first phase of data collection and the second phase of interviewing commenced twelve months after this. Chapter 8 provides an account of the context and methods used to enact this phase of the study which involved interviewing seventeen midwives as they were in the process of adapting their midwifery practice to this new and much larger maternity hospital.

Chapter 9 provides a brief introduction to the findings to this phase of the study.

Chapter 10 provides an account of the chaos the midwives experienced with the transfer of services and the opening of the new hospital. This led the chapter to be titled 'The Storm' as it describes the disarray staff encountered in this new environment.

Chapters 11 – 13 are an account of the findings of this phase of the study which is the midwives' lived experience of working in this large maternity unit. These findings fell into three themes. The storm metaphor is continued as the terms 'Weathering the Storm', 'Escaping the Storm' and 'Eye of the Storm' epitomised how the midwives experienced midwifery in the new setting. The throughput of women giving birth in this labour ward continued as an unabated storm of activity, yet the midwives escaped from this as they entered rooms to care for individual women in labour. The activity outside the room meant that there was little interference in the care that they provided, and, as a result their relationships with women were stronger. Midwives had opportunities to innovate their practice, and as a consequence, the care that they provided was more women centred than previously.

In Chapter 14 the data from Chapters 7, 9 and 10 are discussed. There were elements of the midwives' experience of working in the old hospital which were similar to the new larger hospital, and which reflected Lipsky's (1980/2010)<sup>1</sup> analysis of public service for which he coined the phrase 'street level bureaucracy'. This concept highlights the difficulties public servants experience in attempting to provide individualised client centred care where bureaucratic systems prevail. Foucault's work on the nature of power and surveillance was also evident. These data also revealed the impact the environment for childbirth has on midwifery identities. This is considered in terms of Lindemann Nelson's (2001) work, whereby she noted that the identity of an occupational group can be fractured and disempowered by a more powerful other.

Chapter 15 discusses the more positive findings of the impact of the move to a large maternity unit. Specifically, and as a new interpretation, the findings revealed a paradox whereby, due to the increased workload of all staff, the labour ward midwives escaped from what has been termed the Foucauldian Panopticon of obstetric (and midwifery) surveillance (Arney 1982). In the hectic workload there was no longer a consensus approach to care. In providing one-to-one care the midwives worked in relative isolation. Maintaining a phenomenological approach to the study, the work of Merleau-Ponty (1962) emerged as a framework to discuss these unexpected findings which revealed that, in this much larger hospital,

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<sup>1</sup> Michael Lipsky's book *Street Level Bureaucracy* was first published in 1980. It has never been out of print and a 30<sup>th</sup> Anniversary edition was published in 2010.

midwives had greater autonomy in caring for women in labour and birth than previously. This was because they were now working in a labour ward where they were not under direct obstetric or midwifery surveillance and the focus of one-to-one care of women was maintained. This new setting had enabled nascent midwifery practice towards normalising birth to emerge.

Chapter 16 contains a brief reflective review of my experience in undertaking this study.

Chapter 17 summarises the conclusion and provides a final discussion on the results of this study and includes recommendations for education, practice, service organisation and further research in this area.

It is hoped that the findings from this study will have implications for an understanding of the labour ward midwife's role and the type of maternity care that is delivered in large, publically funded maternity hospitals.

# SECTION 1 SETTING THE SCENE

## CHAPTER 2 BACKGROUND

### **Introduction**

Within much of the literature on contemporary childbirth, the term ‘medicalised’ is often generically applied to a package of care that includes a hospital birth with doctors nominally as the lead care givers (DeVries and Barroso 1997). Conventional maternity care includes a range of practices which involve surveillance and monitoring and the routine use of technology in the assumption that this provides best outcomes for women and their babies. Within this model, while doctors are nominally the lead care givers, midwives or obstetric nurses are part of the package of maternity care provided. The extensive critique of medicalised childbirth is always associated with hospital birth. This chapter explores the background to the debate on hospital based maternity care, in particular how this impacts on childbearing women and the midwives who work in this environment.

Over many decades a criticism of the medical management of childbirth has developed from a wide range of fields including; anthropology (Jordan 1993, McCourt 1998, Davis-Floyd 2001), sociology (DeVries and Barroso 1997, Murphy Lawless 1998, van Teijlingen et al. 2000, Kennedy 2004), medicine (Arney 1982, Johanson et al. 2002, Odent 2002, Wagner 2006), midwifery (Anderson 1999, Kirkham 1999, Kennedy 2002b, Downe 2008a) and childbirth education (Robertson 2000, Kitzinger 2005, Simkin 2007). These authors variously argue that for the majority of women the medicalised approach to pregnancy and childbirth serves to increase intervention in labour, which impacts on women’s birth experience; reducing their chance of achieving a normal birth without the expected improvement in outcomes.

While midwives and childbirth associations favour an approach to birth with minimal intervention, there is no strong evidence that women are dissatisfied with contemporary maternity care (Sadler et al. 2001, Dickinson et al. 2003, Green and Baston 2007). The choice of intervention is even considered rational in a society where pharmaceutical and technological interventions are accessible and commonly



accepted (Hewer et al. 2009). However, there is also increasing awareness of the consequences of traumatic events which can surround birth (Skari et al. 2002, Beck 2004, Thomson and Downe 2008, Parfitt and Ayers 2009, Elmir et al. 2010). Memories of birth can be retained for many years and, where childbirth is perceived as distressing, this may have profound and lifelong effects (Maugher 1998, Thomson and Downe 2008). Negative birth experiences have been related to a number of factors, including intervention in labour, lack of control and poor support (Ryding et al. 1998, Waldenstrom et al. 2004, Lundgren 2005, Lobel and DeLuca 2007, Goer 2010). Women with positive experiences tend to recall the support they received from caregivers while those with negative memories recall negative interactions with staff (Simkin 1991, Simkin 1992).

The medical model is often contrasted negatively with a midwifery model or social model of birth. The social model is consistent with a midwifery ideology that pregnancy and birth are normal physiological life events. It is seen as non-interventionist and women centred in its approach. In contrast, the medical model *'is more aligned with objective positivism and governmentality at societal, institutional and individual levels'* (MacKenzie Bryers and van Teijlingen 2010 p. 494). This is connected to the different ways obstetricians, midwives and women perceive risk. Both social and medical models and risk management are required in contemporary maternity care (MacKenzie Bryers and van Teijlingen 2010).

Within the literature, in the social model of childbirth, there is an assumption that midwifery care is 'good' for women experiencing normal birth, and medical care is 'bad' (Walsh 2009a). The possibility of midwives contributing to the medicalisation of childbirth is rarely mentioned.

## **2.1 Normal or technocratic birth: competing paradigms**

In 1997, the World Health Organisation (WHO) stated that the process of giving birth should only be interfered with for valid reasons. Yet despite this, statistical trends have shown a steady increase in procedures such as: induction of labour, electronic fetal heart monitoring, amniotomy, forceps, vacuum extraction and caesarean births (Kozak and Weeks 2002, Declercq et al. 2006). This is despite the evidence that these interventions can lead to adverse outcomes when they are

routinely applied (Enkin et al. 2006, Wagner 2006). Of increasing concern internationally is the rising caesarean section rate (Euro-Peristat 2008, Hamilton et al. 2009) and the impact this has on women, including the potential for severe morbidity and mortality (Villar et al. 2006, Lobel and DeLuca 2007, MacDorman et al. 2008, Guise et al. 2010, Souza et al. 2010).

To this debate on the nature of contemporary childbirth, Davis-Floyd (1994) introduced the term technocratic birth. This came from her observation that the changes in maternity care occurred in parallel with an increasing reliance on technology throughout society. In this interpretation both doctors and midwives accept high levels of intervention and readily adopt prevailing technology in the belief that it leads to best outcomes for women and their babies (Davis-Floyd 2001). This term takes the emphasis away from the medical profession, as being solely responsible for the levels of surveillance and intervention in childbirth, acknowledging that doctors too are also caught in this technocratic age (Wagner 2001).

Alongside the growth in technology the call for natural childbirth has been prevalent for many decades (Arney 1982, Murphy Lawless 1998, Maternity Care Working Party 2007). Repeated efforts have been made to define normal birth but despite this, a consensus has not yet been achieved (Downe 1996, Duff 2002, Deery 2005, Downe 2006, Kennedy et al. 2010). The World Health Organisation (WHO) (1997) defines normal birth as 'spontaneous in onset, low-risk at the start of labour and remaining so throughout labour and delivery. The infant is born spontaneously in the vertex position between 37 and 42 completed weeks of pregnancy; after birth, the mother and infant are in good condition' (p. 3). This definition may include acceleration of labour, amniotomy, epidural anaesthesia and the use of episiotomy. In contrast, Gould (2000) describes the attributes of normal birth as a physiological labour which follows a sequential pattern. The woman experiences painful regular contractions which stimulates progressive effacement and dilatation of the cervix and the descent of the fetus. This culminates in the spontaneous vaginal birth of a healthy baby and the expulsion of placenta and membranes with no apparent complications in mother or baby. It is strenuous work, and movement has a crucial role. Birth Choice UK (2005) use a simpler definition and describe normal birth as

labour and birth without medical intervention, while Mead (2008) suggests that normal birth is situated somewhere between a pure physiological approach at one end of the spectrum and a medicalised approach at the other.

While the debate about normal birth continues (van Teijlingen 2005), other terms have also been suggested which may be more appropriate to the needs of individual women. At a practice level, 'unique normality' (Downe 2006) or 'optimal birth' (Kennedy 2006) are both terms which recognise the diversity of the birth experience for individual women and avoid the dichotomy that characterises birth as either 'normal' or 'abnormal'. Both authors suggest that those providing maternity care can maximise the possibility of a normal labour and birth with minimal use of interventions in order to achieve the best possible outcomes for women and their babies. The terms also acknowledge that women can have a positive birth experience that is far from physiological. Thus all eventualities in childbirth are covered, including complications, where intervention is required to ensure best outcomes for mother and baby.

While a 'normal' birth as described by Gould is rare in conventional hospital based maternity care settings, those who favour a less interventionist approach argue that women experiencing normal childbirth can be empowered by this experience (Halldorsdottir and Karlsdottir 1996, Lundgren and Dahlberg 1998, Lundgren 2005, Edwards 2005, Leap and Anderson 2008).

## **2.2 Beliefs about birth**

Another concern for contemporary maternity care is that there is emerging evidence that higher rates of 'normal birth' are linked to beliefs about birth and the implementation of evidence based practice (Kennedy et al. 2010). Where there is a belief in providing supportive care to women in labour and in utilising the least intervention possible, women appear to have the best opportunity to have a good birth experience. In Canada, a review of four hospitals found that the crucial factors in maintaining a low caesarean section rate included the attitude of the staff towards childbirth, a pride in a low caesarean section rate and a culture where birth is viewed as a 'normal physiological process' (Ontario Women's Health Council 2000). This variation of attitude towards birth was also found in England where some midwives

reported that there was a 'normal philosophy' in their unit and others stated that the 'medical model of care' was dominant (Lavender and Chapple 2004 p. 328).

Whether this is a cause or effect is difficult to determine but it has been demonstrated that high levels of intervention can impact on the attitudes of staff. Mead (2008) found that midwives working in units with high rates of intervention generally perceived intrapartum risks to be greater than midwives working in lower intervention units. These midwives underestimated the ability of low risk women to progress normally and overestimated the advantages of medical interventions. Mead concluded that the environment plays a crucial role in shaping midwives' appreciation of intrapartum risks, and that attention needs to be given to the influence the workplace has on the organisational culture of a unit and the associated rates of intervention.

A recent ethnographic study which explored efforts to normalise birth, highlights the complexity of this issue within contemporary maternity care (Kennedy et al. 2010). Kennedy et al. identified three strategies which were most likely to support normality. These are: an 'ethos' of normality, 'working' the evidence, and 'trusting' women to make informed choices. Barriers to normalisation were found to include the inappropriate use of technology, disregarding a woman's risk status for labour, a lack of medical training in normal birth, and poor staffing levels. It thus appears that there is an on-going challenge to normal birth even where there is an ethos within a maternity service to support it.

### **2.3 Midwives and the growth of technology**

In many parts of the world, midwives are the health professionals who are best educated to provide care for women during normal pregnancy and birth (WHO 1997, ICM 2005), yet in moderate and high resource countries, midwives have adopted many of the advances in technology without much debate. Though midwifery is underpinned by a philosophy of normal childbirth, it has been reported that hospital based midwives acquiesce to a technocratic approach to care as it is easier for them to comply with institutional norms (Hindley et al. 2006, Parsons and Griffiths 2007). Sinclair and Gardner (2001) reported that midwives reject the possibility of being over dependent on technology and Kennedy (2002b) found that even midwives who

support normal birth may adopt technology in order to optimise birth outcomes and possibly reduce the need for further interventions.

The term the ‘medicalisation of childbirth’ is somewhat problematic as it implies that the power in this model of care lies with the medical profession and does not consider midwives’ potential contribution to this approach. As stated, midwives do not acknowledge the role they play in the ‘medicalisation of childbirth’ (Anderson 1999) and it has been reported that it is difficult for hospital based midwives to practise autonomously (Pollard 2003, Reid 2007). This is due to the institutional environment in which they work where midwives confront competing demands and where technology and intervention is the norm. In this setting, midwives lack recognition of their potential to contribute and enhance maternity care and birth outcomes (Mander and Fleming 2002, Reid 2007). Midwives, who have only worked in hospital settings, may accept high levels of intervention in the belief that it optimises birth outcomes. However, there is evidence of midwives using different approaches to care in hospital settings, some being more supportive in providing woman centred care and others being more clinically focused (McCrea et al. 1998, Bluff 2003, Hallgren et al. 2005, Porter et al. 2007). What midwives say about childbirth in a hospital environment will be further explored in Chapter 4.

#### **2.4 Midwives’ contribution to maternity care**

A Cochrane review comparing midwife-led care with other models of care found that women who received midwifery led care were less likely to experience regional analgesia<sup>2</sup>, episiotomy or instrumental delivery (Hatem et al. 2008). They were more likely to feel in control during labour and childbirth and to experience spontaneous vaginal birth. There were no differences between groups for fetal loss or neonatal death (Hatem et al. 2008). These findings related to situations where continuity of midwifery care was provided and women had established a trusting relationship with the midwife prior to labour; a feature not commonly found in obstetric led services. More recently, a systematic review and economic analysis of midwife led models of care concluded that, even where antenatal care is not a component, the majority of women will benefit from midwife-led models of care without any adverse consequences for them or their infants (Devane et al. 2010). It is unfortunate that in

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<sup>2</sup> Regional analgesia refers to epidural or spinal anaesthetic

hospital settings, where the type of birth only is recorded, the number of births facilitated by midwives is not easily ascertained.

In North America, which has different midwifery traditions than in Europe (Simkin and Acheta 2005, Kennedy et al. 2010), Davis Floyd (2001) describes postmodern hospital based midwives as those who may come from a tradition of traditional midwifery. These midwives may try to cross the boundaries between obstetric care and alternative care, increasing options for women, which may include the re-incorporation of elements associated with ‘traditional’ birth such as the use of upright positions.

## **Conclusion**

Midwifery is underpinned by the assumption that childbirth is a normal physiological process and in many parts of the world, the midwife accompanies the woman through the labour and birth and has responsibility for her care. Within the maternity services it can be difficult for midwives to practise autonomously. Midwives are often constrained by legislation and regulation and they frequently lack recognition of their potential to contribute and enhance maternity care and birth outcomes (Reid 2007).

This chapter has explored the current debates in maternity care. This includes the increasing use of technology and intervention in childbirth and the concerns raised in many disciplines, from medicine and midwifery, to sociology, anthropology and others and about the impact that this has on women’s experience of birth. The concept of ‘normal birth’ was discussed in the context of contemporary beliefs about childbirth and the potential that midwives have contributed, rather than resisted this growth of technology.

Different issues prevail in community settings, but, as in the developed world most births occur in hospital; this study explores the perceptions and experiences of midwives in this environment. Through this it was hoped to develop an understanding of the issues that impact on midwifery practice and to explore the apparent paradox whereby hospital based midwives purport to support normal birth, but they practise in an environment where intervention is the norm. In the next

chapter the situation for midwives in Ireland will be outlined to provide a context for this study.

# CHAPTER 3 MATERNITY CARE IN IRELAND

## **Introduction**

A recently published Irish report stated that, ‘maternity-care policies are lagging behind in terms of models of care available to women such as those available in Britain and other European countries’ (Begley et al. 2009 p. 16). As this present study was undertaken in Ireland, a review of the Irish maternity services is provided in this chapter along with an exploration of the factors that impact on the provision of maternity care and the activities of midwives.

## **3.1 Maternity service provision**

In Ireland, care is provided under the Mother and Infant Care Scheme which offers free maternity services to all pregnant women (Department of Health and Children 2011). This includes care from a general practitioner until six weeks after the birth and hospital outpatient and inpatient care under the direction of a consultant obstetrician. Apart from maternity care, free health care is otherwise limited to those who qualify for a Medical Card with various charges applying to everyone else. Though everyone is entitled to some level of public health care, it has long been Government policy to encourage individuals to subscribe to private health insurance (Colombo and Tapay 2004). Ireland has one of the highest levels of private health coverage in the Organisation for Economic Co-operation and Development (OECD) (Nolan 2005), with half the population (50.7%) in one of the several insurance schemes (Health Insurance Authority 2010). Both public and private obstetric care is available in all 19 public maternity units, and though the contribution of midwives to the Mother and Infant Scheme (Department of Health 2004) is not readily apparent, midwives are employed within these units to support the obstetric led service.

Private health insurance has a significant impact on the maternity services (Klynveld Peat Marwick Goerdeler (KPMG) 2008) and women who opt for private care may receive little or no midwifery input during their pregnancy. These women access private or semi-private beds in public maternity hospitals. Midwives provide intrapartum care but the consultant obstetrician attends the birth. The growth in the Irish economy and the poor state of the health service in general has encouraged



many individuals and families to opt for private health care (Wiley 2001). As more recent economic pressures have impacted on the wealth of individuals it remains to be seen how this will impact on the numbers able to afford private maternity care.

Since the 1970's it has been Government policy that all women should give birth in consultant led maternity hospitals (Department of Health 1994). Within the public system maternity care is fragmented and provided by multiple caregivers. While hospital doctors move through clinical settings, midwives generally work in just one area; antenatal clinics, labour ward or antenatal and postnatal units. Midwives clinics are available in some hospitals, but most women will receive all their antenatal care from their general practitioner and a variety of hospital doctors; or, if 'private', their chosen obstetrician. As in other countries, the caesarean section rate has increased, and, in 2009 it was 27% with 57% of women experiencing a spontaneous vaginal birth (Economic and Social Research Institute (ESRI) 2011).

The work of the midwife is organised around the services provided by hospital doctors. In antenatal clinics midwives book pregnant women into the service, organise tests and appointments and provide antenatal classes. Most women will see a doctor at each visit. When a labouring woman comes to hospital she will be assessed by a midwife and transferred to the labour ward for intrapartum care. Here, all care is provided by midwives unless problems arise. In this situation an obstetrician will become involved in the birth. Following the birth, the woman and her baby are transferred to a postnatal ward where care will be provided by another group of midwives. The average hospital stay for all women accessing maternity services is 2.9 days (ESRI 2010) but pressure on postnatal beds may lead to earlier discharge. The three large Dublin hospitals provide an Early Transfer Home Scheme for those discharged within 48 hours of the birth; these women receive home visits by a midwife. In Limerick, a similar home visiting service is available. Outside of these schemes, postnatal home visits are provided by a public health nurse.

In Ireland, as elsewhere, this form of obstetric led maternity care is described as a medical model of care (Murphy Lawless 1998, O'Connor 2001, Devane et al. 2007, KPMG 2008). It has been reported that within this service midwives have little recognition in the care they provide and have little autonomy in their practice

(McCrea and Thompson 1995, Higgins 2007, Keating and Fleming 2009, Daly and O'Boyle 2010).

In the past 50 years many small maternity units have closed and services transferred to large centralised units (Kennedy 2002a). The most recent national figures available are for 2008. In this year, 47% of births took place in units accommodating over 8,000 births annually (ESRI 2011). In 1998 it was revealed that an unusually high number of caesarean hysterectomies had been performed in one maternity unit. Some of the difficulties experienced were attributed to the professional isolation of the health professionals employed there. While there had been a number of inspections by the General Medical Council and An Bord Altranais (the Nursing Board)<sup>3</sup>, obstetric and midwifery practices were never questioned or audited (Government of Ireland 2006). Details of this event are provided below but the findings from the inquiry into the practices in this unit have led to concerns about other isolated units. The closure of three units in the south of the county with a transfer of services to a large new maternity hospital created the fourth unit with more than 8,000 births per year.

### **3.2 Home Birth Services**

The availability of home birth and community midwifery services is restricted by geographical location and the availability of midwives to provide the service (O'Connell and Cronin 2002). While the Health Act 1970 requires health boards 'to make available appropriate medical, surgical and midwifery services' the Supreme Court has ruled that this obligation is met by providing these services within hospital (Haggerty 1999). Domiciliary births are resisted by obstetricians and general practitioners for reasons of 'safety for mother and baby' (O'Connell et al. 1998, McKenna and Matthews 2003, Evans and Harris 2004). In a review of three funded community midwifery projects which were all positively evaluated, the Review Group reported on the animosity they received from various sources and subsequently stated that:

*In order for the Department of Health and Children, the public, obstetricians and midwives and health care staff in general to have confidence in*

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<sup>3</sup> An Bord Altranais is the statutory body which regulates nursing and midwifery in Ireland.

*midwifery care, a change of mindset will be required.*

*(Domiciliary Births Group 2004 p. 15)*

The movement around home birth continues, and apart from the few publicly funded initiatives, home births are provided by a small number of independent midwives (15 currently listed by the Home Birth Association [www.homebirth.ie](http://www.homebirth.ie)). To meet the on-going demands from women, a state insurance scheme is now available to independent midwives who comply with certain conditions (Millar et al. 2008). Since this was introduced, the number of births facilitated by independent midwives has fallen from a peak of 288 in 2002 to 148 births in 2009 (ESRI 2011). Births facilitated by hospital administered home birth schemes are recorded as hospital births.

### **3.3 Midwifery led units**

While the small number of domiciliary projects were being developed and evaluated, another initiative occurred in the North Eastern Health Board area (now Health Services Executive (HSE)<sup>4</sup> North East). Following the closure of two maternity units in Roscommon and Dundalk two reports were undertaken (Condon 2000, Kinder 2001) which led to the setting up of midwifery led units attached to established maternity units in Cavan and Drogheda. The evaluation of this project demonstrated that midwifery-led care in Ireland is as safe as consultant-led care, results in less intervention, is viewed by women with greater satisfaction, and is cost effective (Begley et al. 2009).

This project had consumer involvement from the initial concern at the closure of the two maternity units to the establishment and monitoring of the new service (Devane et al. 2007, Kennedy 2008). It remains to be seen if this initiative will lead to the reopening of maternity services in Roscommon and Dundalk as originally proposed (Kinder 2001). The more recent KPMG Report (2008) which looked at the development of maternity services in Dublin endorsed this model and recommended that midwifery led units should be provided adjacent to obstetric units to ensure that

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<sup>4</sup> The Health Service Executive (HSE) is the body responsible for delivering health and personal social services in Ireland. For administrative purposes, there are four regional areas: HSE Dublin Mid-Leinster, HSE Dublin North East, HSE West, and HSE South. The HSE replaced 11 regional Health Boards in 2005.

consultant cover is available if required. This is perceived as offering choice to women while providing a cost effective maternity service which has capacity for an increased number of births.

### **3.4 Lourdes Hospital Report**

As mentioned above, the activities in one maternity unit became widely publicised in 1998 when it emerged that the practices by two obstetricians were largely unquestioned for 25 years (Government of Ireland 2006). During this time 188 women experienced caesarean hysterectomies, 129 of which were performed by one obstetrician. The practice was brought to the attention of the Health Board by two newly appointed midwives. This eventually led to an inquiry into the activities of the obstetrician being conducted by Justice Harding Clark. The report provides an insight into the maternity practices and the activities of midwives in this unit and some findings are worthy of presentation here.

On compiling the report, Harding Clark reported that a hierarchical approach to hospital care was evident. The practices of doctors and senior staff were unquestioned and caesarean hysterectomies had become normal practice for the management of 'postpartum haemorrhage' (PPH)<sup>5</sup>. The matron<sup>6</sup> had raised her concerns with obstetric consultants on a number of occasions and was told that this was a clinical issue and was not a concern. An underlying assumption by some of the staff was that as the Catholic ethos of the hospital did not permit tubal ligations at least some of these hysterectomies were for purpose of sterilization; yet many of the women were young and of low parity. The women were generally informed by the consultant that the emergency surgery was life-saving and they were unaware that many other '*young women had been needlessly deprived of their uterus*' (p. 248).

Harding Clark noted that most of the midwives had trained in that unit and had not worked elsewhere. They were caring and committed to their work, but were submissive to doctors and senior staff. Many had no concerns about obstetric

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<sup>5</sup> Postpartum haemorrhage (PPH) is defined as a postpartum blood loss greater than 500mls and a hysterectomy rarely required to manage this condition as a range of less invasive methods are available. Many of the women who experienced a caesarean hysterectomy did not require blood transfusions indicating that blood loss may not have been excessive.

<sup>6</sup> Matron is the term used in the report but holders of this post are now called Directors of Nursing or Midwifery as appropriate.

practices and those that had concern had no confidence to take this to a higher level. One midwife stated that the '*concept of patient advocacy was unknown*' (p. 188) and their training had '*moulded them never to question*' (p. 317). The midwives did not expect to be accountable for their own practice.

The midwives who were interviewed by Harding Clark fell into a number of groups; one group had no concerns and remained largely supportive of the consultant. Another, the largest group were deeply distressed when events unfolded and these midwives blamed themselves for not suspecting that something was wrong. Most had accepted the practice of caesarean hysterectomy. Any who had some disquiet reported that, as other obstetricians, anaesthetists and the matron, were 'aware' of the procedures when they took place, they had no confidence in the legitimacy of their concerns (p. 192). The third group were 'junior midwives' who had worked in other hospitals and raised their misgivings with other midwives. They were also of the belief that this consultant and the practices in the unit could not be criticised but eventually, following a change in the management of the hospital, it was one of these midwives that led to the practice being revealed.

The recommendations made by Harding Clark are extensive and consistent with current recommendations for good governance of a health service facility. Some were directed at the midwives and are thus worth reporting. It was recommended that midwives and junior doctors (who are put in the same category) do not challenge decisions made by consultants but that there is a '*teamwork approach with appropriate discussions before and after events*' (p. 323). This recommendation was not made for the consultants. She also mentions that midwives should '*avoid assumptions that 'natural' delivery or 'managed labour' is superior or that obstetricians or anaesthetists are interventionist*' (p. 323). While the justification for this statement is not clear from the report, presumably at least some of the midwives raised concerns about a medicalised approach to birth in the unit.

This very public media event did not just challenge the maternity services but, could explain more recent changes within the Irish health care system, including changes to the legislation that governs the practice not just of doctors but of nurses and midwives as well. The forthcoming changes to the Nurses Act (1985) will provide greater lay representation on An Bord Altranais, which will also be required to

change its name to An Bord Altranais agus Cnáimhseachais na hÉireann (the Nurses and Midwives Board of Ireland) (Nurses and Midwives Bill 2010) (Spiers 2008).

### **3.5 Recent reports on maternity care**

A national review of obstetric services was undertaken to review the medical staffing of maternity units (Institute of Obstetricians and Gynaecologists 2006). The report highlights a lack of choice in service provision and difficulties encountered for women who live distant from their nearest unit. Included in the recommendations is the continued involvement of obstetricians in the care of all pregnant women in order for obstetricians to maintain their expertise in normal pregnancies. The report endorses the development of ‘Domino<sup>7</sup>’ services to ‘address the demand for home births whilst ensuring safe care for women and babies’ (p. 36).

A more recent extensive independent review of Dublin services supported the development of community based maternity services which should be woman centred and provide increased choice and continuity of care for women (KPMG 2008). The KPMG Report highlights the under developed services led by and/or delivered by midwives which they suggest is largely due to the structure of private medical insurance. The report recommends giving midwives greater autonomy in the care of low risk women and to provide them with equity alongside GPs and obstetricians. It is unclear if the findings of this report will be implemented.

### **3.6 Women’s views of the maternity services**

Few published reports on the maternity services in Ireland ascertain the views of women. One survey undertaken in the Western region found that the majority of women was satisfied with their care but agreed that midwifery led care and a home birth service should be provided. These services were not readily available in the region (McCarthy et al. 2005). Midwives were also surveyed. While most stated that women’s physical needs were met, many reported that they did not have the opportunity to consider psychological issues. Workload compromised the amount of midwifery care they could provide and most stated that midwifery led care should be

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<sup>7</sup> DOMINO (Domiciliary In and Out) is a term used where the woman receives her antenatal care in the community with a midwife, she attends a maternity hospital for the birth, usually accompanied by her community midwife, and returns home shortly afterwards under the care of a midwife.

made available. The authors suggest that further research should consider ways to support women, midwives and doctors in supporting natural labour without interventions.

Another survey of postpartum women, this time from a Dublin hospital, revealed that analgesia, particularly epidural analgesia, vaginal birth, and experiencing empathetic communication were significantly associated with higher levels of satisfaction (Geary et al. 1997). The only other published studies on women's views of maternity services are a series conducted by a daily newspaper (Irish Examiner 2006) and surveys by a consumer group, the Association for the Improvement of Maternity Services (AIMS) who conduct and publish results of their surveys online ([www.aimsireland.ie](http://www.aimsireland.ie)). While all show a general level of satisfaction with maternity care, they also note the negative experiences of some women, and the lack of choice that was apparent, in terms of place of birth and type of caregiver. National surveys have not been conducted.

### **3.7 Regulation of midwives**

One of the difficulties experienced by midwives in Ireland is that they are required by their professional regulation to provide women centred care and support normality in birth (An Bord Altranais 2010), yet they have little autonomy within the hospitals where they are employed (Higgins 2007). Few midwives who received their midwifery education in Ireland have had the opportunity to work outside of the hospital environment.

The current legislation that governs midwifery is the Nurse's Act (1985) which states that the term *"nurse"* means a woman or a man whose name is entered in the register and includes a midwife and *"nursing"* includes *"midwifery"* (Part 1 Section 2). As a consequence official documentation which mentions 'nurses' is taken to include midwives and many midwives have been employed as 'nurses with midwifery'. It is therefore not possible to identify the number of midwives employed as hospital census returns tend to include midwives in their total numbers for nursing staff (Department of Health and Children 2000).

In 1997, following a period of industrial unrest, a Commission of Nursing (sic) was established to review the concerns of nurses and midwives (Government of Ireland 1998). There was extensive consultation and midwives and midwifery organisations had the opportunity to voice their concerns through written and oral submissions. The final report was welcomed by midwives as the first Government publication to acknowledge the separate identity of midwives. The changes to the legislation are due to be enacted this year which will remove this inequity (Nurses and Midwives Bill 2010).

### **3.8 Midwifery practice within Irish maternity services**

Apart from the inquiry into the activities of the Lourdes Hospital detailed above, there have been a number of studies involving midwives and midwifery practice within the Irish health care system. The first of these sought to explore the midwife's role in a teaching hospital using both interviews and observation (McCrea and Thompson 1995). McCrea and Thompson reported that there was evidence of the medical model of care which focused on the physical rather than emotional or psychosocial aspects of care. While the midwives reported that they had autonomy this was not apparent in the observation of their practice.

A study by Begley (2001a, 2001b, 2002) explored the experiences of a national cohort of post-registration student midwives as they progressed through their two year programme. Similarly to McCrea and Thompson (1995), this study reported that the students were required to focus on meeting women's physical needs rather than their emotional ones (Begley 2002). The students portrayed a hierarchical work environment with students in a subordinate role.

In one of two Irish studies which have explored the labour ward environment for midwives in Ireland, Hyde and Roche-Reid (2004) interviewed twelve experienced labour ward midwives from three maternity units. From the accounts provided by the midwives, the researchers concluded that a technocratic approach was evident in the care that midwives provided. Interventions were used routinely, and active management of labour was used to regulate childbirth, though its use varied among midwives. While some defended the moderate use of technology they acknowledged that many interventions occurred to manipulate labour for reasons other than the



health and well-being of the mother or baby. The midwives recognised that unnecessary use of interventions restricted their role, but the choices they offered women were limited by the dominance of obstetric practice. Client passivity was also a factor.

More recently, Keating and Fleming (2009) undertook interviews with ten experienced labour ward midwives from three maternity units. The purpose was to ascertain the midwives' experiences of facilitating normal birth in an obstetric led unit. Findings here also highlight the hierarchy within the maternity services with consultant obstetricians at the top followed by senior midwives. 'Active management of labour' was the norm and, according to the midwives, doctors directed all care. The midwives were frustrated at not being able to utilise their midwifery skills and stated that they could be ridiculed by their midwifery colleagues for not adopting the medical model of care. As in the Hyde and Roche-Reid (2004) study, the midwives reported that many interventions in labour were not evidence based. The findings from both these studies are included in the metasynthesis of midwifery practice detailed in Chapter 4.

All the studies and reports undertaken in Ireland highlight the lack of choice and continuity of care for women accessing maternity services. For midwives the opportunities to provide more direct care to women is constrained by the construction of the maternity services and the lack of recognition of midwives within the health services. Within this system midwives do not have autonomy for their own practice. In the studies that looked at this, midwives stated that they were powerless to bring about change and blamed the prevailing situation on the medicalised environment in which they worked (Hyde and Roche-Reid 2004, Keating and Fleming 2009).

## **Conclusion**

From this review of the Irish maternity services it is apparent that midwives in Ireland, as in other parts of the world, have little autonomy in their work, but at least some continue to advocate for normality in childbirth. As elsewhere, the official midwifery philosophy is underpinned by the assumption that childbirth is a normal physiological process (An Bord Altranais 2010), yet midwives participate in the

routine interventions common in maternity units. Both professional regulation and the education of midwives strive to ensure that midwives have the knowledge and skills to provide care throughout the childbearing period. Thus far the maternity services do not enable midwives to deliver this level of service. Since the report of the Commission on Nursing (sic) (Government of Ireland 1998) midwives have used opportunities to increase their professional visibility. This has been hampered by a lack of understanding of the midwives' role (Higgins 2007).

The question that the next chapter seeks to explore is the issues which impact on midwifery practice whereby hospital based midwives purport to support normal birth but practice in an environment where intervention in childbirth is the norm.

# CHAPTER 4 METASYNTHESIS OF MIDWIVES' EXPERIENCE OF HOSPITAL PRACTICE

## **Introduction**

As has been explored in Chapter 2, where childbirth takes place in hospital there are concerns about the number of routine birth interventions used in labour and the impact this has on women and their babies. Having searched the literature for research on midwives' experience of working in a hospital labour ward, a number of studies emerged which involved interviews or observation of midwives. These provided an insight into hospital birth from the perspective of midwives themselves. To achieve an understanding of this perspective prior to undertaking my own study, I undertook a systematic approach to this literature by conducting a metasynthesis. This is presented in this chapter. The objective of the review was to explore midwives' perceptions of hospital midwifery with a particular focus on labour ward practice. The findings of this chapter were published (O'Connell and Downe 2009).

## **4.1 Metasynthesis**

Metasynthesis is a technique to systematically explore qualitative research. It enables similar studies to be compared and contrasted to discover if the same essential features are found in all of the studies (Sandelowski et al. 1997, Thorne et al. 2004). The findings are then integrated in order to generate consensus on a new construction or description of the phenomenon of interest. From this new conclusions are drawn, which are representative of all data (synthesis) (Jensen and Allen 1994). The process seeks to provide deeper integration and further analysis of the original studies through a process of reciprocal translation (Noblit and Hare 1988). Conducting a metasynthesis has emerged as a relatively new approach for qualitative researchers. It enables them to increase their understanding of a particular phenomenon of interest (Paterson et al. 2001, Walsh and Downe 2005, Sandelowski 2006). The technique can also serve to increase the credibility and trustworthiness of the original studies (Walsh and Downe 2005).

The approach used here stems from original work by Noblit and Hare (1988), who developed a method of combining and creating a synthesis from the findings of

similar ethnographic studies, an approach they termed meta-ethnography. They proposed that studies can be translated into another, literally exchanging metaphors, ideas and concepts from one to the other. The important contextual signifiers of each are respected and while the original meaning is preserved new meanings can emerge (Noblit and Hare 1988). Some authors claim that ethnographies on similar topics were suitable for this synthesis but mixing phenomenology and grounded theory with ethnography makes this mutual translation questionable because of the contrasting way truth is constructed (Jensen and Allen 1996). Others accept that different methodologies can be used if each is made explicit (Sandelowski et al. 1997, Zimmer 2006). These writers maintain that, as metasynthesis is an interpretive integration of findings that are themselves interpretive synthesis of data, different methodological approaches can be included. This approach was essentially accepted by Noblit in his contribution to a later paper on this topic (Thorne et al. 2004).

A risk in conducting a metasynthesis is that, by combining interpretations, generalisations can emerge which lose the uniqueness of the individual studies. As in all interpretive approaches, the intent is not to generalise but to develop new understandings (Guba 1990). To achieve this, a metasynthesis must be careful not to misrepresent the original data.

## **4.2 Strategy**

This work was developed in collaboration with my supervisor (SD) and was based on an approach used in a number of earlier papers (Walsh and Downe 2005, Walsh and Downe 2006, Downe et al. 2007, Downe 2008b). To maximise rigour, an iterative approach was used for topic definition. Once this was determined, there was tight control over the inclusion and exclusion of studies, including study quality and analysis. The processes were closely aligned to those of Noblit and Hare (1988) with two key differences. Firstly, the search strategy allowed for all qualitative methodologies. Secondly, the included studies were assessed for quality, and did not include any that did not meet Lincoln and Guba's (1985) criteria of credibility, transferability, dependability and confirmability.

Constructing a metasynthesis commences by identifying the area of interest which a set of studies could potentially inform. This is followed by extensive and systematic

searching of the literature to locate papers relevant to the area of interest. As a variety of papers are reviewed the metasynthesis becomes more focused to areas that the studies can inform. Further searching becomes more refined and this enables the inclusion and exclusion criteria to be finalised. Searching is an on-going process as criteria become more defined as studies are deemed to be relevant.

At this stage, repeated reading of the qualitative research papers helps to identify if and how they are related, whether interpretive metaphors can be identified and can the studies be translated collectively. Studies are tabulated to assist in this comparison exercise before a final selection is made. Following this and collaboration with others to agree on findings, a synthesis of translations can be constructed (Noblitt and Hare 1988).

The criteria for appraising the quality of the studies involves a comparison of the scope and purpose of each of the studies, their design, sampling strategy, analysis and interpretation, a search for disconfirming data and evidence of reflexivity (Walsh and Downe 2005). In addition, it is important to consider if the ethical dimensions were considered, if the study is relevant to the metasynthesis and whether the findings are transferable. This work is ascertainable by repeated reading of the original studies. This is followed by providing a summary of key concepts until it becomes possible to compare and contrast the identified metaphors, phrases, ideas, concepts, relations and themes from the original texts. Reciprocal translation involves ascertaining if the metaphors used in the studies are commensurate. The concepts from one study can encompass another, or a new set of metaphors can encompass the interpretations in all the studies (Thorne et al. 2004). While looking for reciprocal translation, it is also important to search for any information that might be considered refutational. Refutation is also sought to critically appraise the interpretations and ascertain if alternative interpretations are credible. Following this, it becomes possible to construct a synthesis before the interpretive process is complete.

### **4.3 Researcher reflexivity**

As noted above, this metasynthesis was developed in collaboration with one of my supervisors (SD). In order to enhance the trustworthiness of the review we recorded

our initial position on this topic. We both have extensive experience of working in large hospital labour wards. At the beginning of this review, SD believed that many labour ward midwives felt themselves to be caught in oppressive institutional and inter-professional hierarchies, which they could not resist. Some of the oppressive aspects identified seemed to be in the control of, and even enacted by midwifery staff but this did not fit with midwifery myths about themselves, it appeared to be invisible to them. When I worked in a labour ward in Ireland, Active Management of Labour (O'Driscoll and Meagher 1980) was prevalent and while I accepted the norms of the hospital I preferred to support women who sought a non-interventionist approach to birth. This led me to question the increasingly technocratic approach to childbirth and whether individual midwives' apparent readiness to use interventions impacted on women's birth outcome as well as their experience of childbirth.

#### **4.4 Scoping stage for the metasynthesis**

The purpose of this metasynthesis was to explore midwives' perceptions of hospital birth with particular focus on labour ward practice. The first stage was a rigorous search of English language literature to identify all accessible qualitative research relating to midwives' accounts of hospital midwifery with a particular focus on labour ward practice. This involved an electronic search of databases, the contents of selected journals and relevant conference proceedings (Table 1). A particularly fruitful source of information was back tracking references from selected papers. Books and chapters within books were another source of material and 18 edited midwifery research books were reviewed which identified four relevant studies. Journals and books not available using electronic sources were accessed through two university library catalogues. Date restrictions were not imposed.

**Table 1 Search strategy for metasynthesis**

<b>Databases (18)</b>	BNI, CSA Sociological Abstracts (261 hits, 1 reviewed – repeat), CINAHL, EBSCO, EMBASE, Emerald (92 hits, 0 reviewed), ISI Web of Knowledge (211 hits/18 abstracts reviewed/ relevant), Index of Theses, Informaworld, Medline, MIDIRS, Proquest, PsycINFO, SocINDEX, Sociological Collection, SpringerLink, Swetswise.
<b>Midwifery journals (7)</b>	<i>Birth, BMC Pregnancy and Childbirth, British Journal of Midwifery, Journal of Midwifery and Women's Health, Journal of Obstetrics Gynaecology and Neonatal Nursing, MIDIRS Digest, Midwifery.</i>
<b>Other journals (14)</b>	<i>European Sociological Review, Health, International Journal of Nursing Studies, International Nursing Review, Journal of Advanced Nursing, Journal of the American Academy of Nurse Practitioners, Journal of Clinical Nursing, Journal of Reproductive and Infant Psychology, Nurse Practitioner, Nursing and Health Sciences, Nursing Philosophy, Social Science and Medicine, Sociology of Health and Illness, Health and Social Policy.</i>
<b>Conference Proceedings</b>	Normal Birth Conference (x 2) International Confederation of Midwives (ICM) Triennial Conference (x 3).
<b>Edited texts</b>	18 edited books.

#### **4.5 Search questions**

Databases, social and health science journals were searched using the terms ‘midwife’, ‘midwifery’, ‘nurse midwives’, ‘nurses’, ‘childbirth’, ‘consultant unit’, ‘labour’ and ‘labor’. Relevant professional journals, books and chapters within books were searched for articles that related to midwives’ views or experiences of

midwifery and labour ward care or practices. Midwifery journals were searched by scanning the Table of Contents of electronic journals.

Initially the search questions were quite broad:

- Midwives' accounts of birth in consultant led units
- Midwives' accounts about the nature of midwifery in consultant led units
- Midwives' accounts about midwifery practice in consultant led units
- Influences on midwifery practice in consultant led units
- Midwives' accounts of their relationship with women in consultant led units
- Midwives accounts of their responsibilities in caring for labouring women in consultant led units.

The process of searching and reviewing the literature led to a refinement of the search question for the metasynthesis. While the preliminary focus was on midwives' views of labour ward midwifery practice, it quickly became apparent that many potentially useful studies did not specifically focus on labour ward midwives. Studies were initially reviewed if they contained midwives' accounts of their practice in a hospital setting but many papers focused on specific aspects of practice, such as nutrition in labour, or midwives' attitudes to specific interventions; or defined systems of care, such as team midwifery. Many of these were read to ascertain if they could be accommodated into the metasynthesis but they were eventually eliminated. Tight boundaries were imposed to ensure that the studies reflected the same essential phenomena (Sandelowski et al. 1997). This gradually emerged as midwives' global perceptions of hospital midwifery care and the question thus became:

*What do midwives, who practice in publicly funded maternity hospitals in high resource countries, say about hospital midwifery, with particular reference to labour ward practice?*

Once this decision had been made it became possible to narrow the inclusion criteria to:



- Good quality, qualitative research papers that contain midwives' accounts of midwifery practice in a hospital setting. This could include community and independent midwives if they also provided care in hospital labour wards.
- Research published in English and undertaken in developed countries with a publicly funded maternity care system.

Papers were excluded if they were:

- Research on aspects of midwives' practice e.g. diagnosis of labour, eating in labour, labour pain, communication.
- Research on midwives' attitudes to interventions or systems of care e.g. epidural anaesthesia, fetal monitoring, episiotomy, team midwifery.

Searching of journals continued from February 2005 - January 2009 for newly published work and to ensure that studies were not overlooked or needlessly excluded. Over 216 abstracts were reviewed and many of these papers were read in full (Table 2). At one point a paper was identified that did not add anything new (Earl and Hunter 2006). It therefore appeared that data saturation had been reached. However, the next located study (Porter et al. 2007) questioned this assumption, as, while confirming earlier findings, it added a new dimension to the metasynthesis which was then integrated into the analysis. Two further papers (Blaaka and Schauer Eri 2008, Keating and Fleming 2009) were identified later but they did not add anything new. At this point focused searching stopped in order for the metasynthesis to be constructed.

**Table 2 Selection of studies**

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1. Selection and reading abstracts from 216 studies which loosely met the inclusion criteria
  2. Exclusion of 185 studies as the focus of the metasynthesis became clearer
  3. Remaining 31 studies read repeatedly and tabulated to compare and contrast them and identify if common themes existed
-

- 
4. Excluded 17 studies for a variety of reasons such as insufficient data, or the inclusion of both quantitative and qualitative data
  5. Remaining 14 studies reviewed using Walsh and Downe (2006) framework to assess the quality of the studies and assist in the construction of the metasynthesis
- 

It quickly became evident that some studies emanated from original MSc and PhD work. While a few theses were initially obtained by Intra Library Loan, the difficulties of reading microfiche and the limitations on photocopying material made repeated reading and analysing individual theses difficult. For pragmatic reasons further theses were not sought. An electronic search of unpublished theses did not reveal any new studies.

An issue that led to considerable debate among us were studies undertaken in the United States. In North America the care of women in labour is generally provided by obstetric nurses with nurse-midwives or physicians attending for the birth (Bourgeault and Fynes 1997, Bourgeault et al. 2001, Kennedy and Lyndon 2008). While not initially excluded, four studies from the United States (Scoggin 1996, Foley and Faircloth 2003, Kennedy et al. 2004, Kennedy et al. 2006) were eventually eliminated, as with repeated reading and appraisal it became difficult to compare them with studies where maternity care is publicly funded. This iterative process of topic definition is consistent with metasynthesis as during the searching and exploring of the literature the metasynthesis question becomes more defined (Sandelowski et al. 1997, Walsh and Downe 2005).

#### **4.6 Final selection of studies**

Initially everything that was potentially relevant to the topic was reviewed; this involved reading abstracts and many papers in full. These studies provided a variety of accounts of midwives' experiences, perceptions, and attitudes to intrapartum care or aspects of intrapartum care in a hospital setting. Twenty seven studies were explored using criteria developed by Walsh and Downe (2006). Following this scrutiny fourteen were selected for the metasynthesis. A flow chart was originally developed to display this sequence but it became unwieldy as the searching and

reviewing of studies was a continual process. Details of some of the excluded studies are contained in Table 3.

Selected studies were published between 1995 – 2009. Six focused on labour ward midwives (Hunt and Symonds 1995, Hyde and Roche-Reid 2004, Earl and Hunter 2006, Russell 2007, Blaaka and Schauer Eri 2008, Keating and Fleming 2009), five involved midwives working in a variety of practice settings, including antenatal, intranatal, postnatal or community areas (Kirkham 1999, Lavender and Chapple 2004, Hunter 2003, Davies and Iredale 2006, Porter et al. 2007) and three studies involved midwives who worked in both community and hospital settings (Shallow 2001a, 2001b, 2001c, 2001d, Hunter 2003, Crabtree 2004). Eight of the selected studies were undertaken in Britain, three in New Zealand two in Ireland and one in Norway. Of the selected studies, one was published in a social science journal; the remainder were sourced in professional midwifery literature.

**Table 3 Final exclusion of studies**

	<b>Author, date</b>	<b>Final decision</b>	<b>Reason for exclusion</b>
1.	Berg and Dahlberg (2001)	Excluded	Midwives care of women at high obstetric risk
2.	Dodd, et al. (2002)	Excluded	Midwives facilitating normal birth for women with epidurals
3.	Fleming (1998c, 1998a)	Excluded	Developing a conceptual model of midwifery practice
4.	Foley and Faircloth (2003)	Excluded	Differences in practice in US
5.	Jackson (2002)	Excluded	Insufficient data to assess quality
6.	Kirkham and Stapleton (2000)	Excluded	Focus on the support needs of midwives
7.	Lundgren and Dahlberg (2002)	Excluded	Midwives' experience of their encounter with women and their pain during childbirth
8.	Mackin and Sinclair (1998)	Excluded	Includes quantitative data
9.	McCrea and Crute (1991)	Excluded	Midwives' perception of a therapeutic relationship with clients
10.	McCrea and Thompson (1995)	Excluded	Midwives' role and activities in a maternity hospitals – focused on skill mix

	<b>Author, date</b>	<b>Final decision</b>	<b>Reason for exclusion</b>
11.	McFarlane and Downe (1999)	Excluded	Secondary analysis of data on team midwifery
12.	Murphy Lawless (1991)	Excluded	Insufficient data to assess quality
13.	Kennedy, et al. (2003) Kennedy and Shannon (2004) Kennedy et al. (2004) Kennedy, et al. (2006)	Excluded	Differences in practice in US
14.	Schneider (2002)	Excluded	Insufficient data to assess quality
15.	Scoggin (1996)	Excluded	Differences in practice in US
16.	Thompson (2003)	Excluded	Focused on midwives experience of ethical conflict

#### **4.7 Appraisal of studies**

Each of the studies was read repeatedly to extract the concepts, categories and metaphors used by the original researchers to describe the accounts provided by the midwives interviewed. These were compared and contrasted through reviewing phrases, ideas, and themes in the published accounts, disconfirming data was particularly sought. The quality of the studies was assessed using the tool developed by Walsh and Downe (2006), which is a summary of a wide range of previously suggested quality assessment tools. The characteristics of the included studies are presented in Appendix 1.

#### **4.8 Iteration of themes**

The emergent themes were discussed extensively and the studies were repeatedly re-read to consider their veracity and for any evidence that could be considered refutational (Noblit and Hare 1988). After some debate a consensus on the themes and the synthesis was reached (Table 4). Of particular interest here was the study by Porter et al. (2007). Unlike all the others, this one, along with the oldest of the studies (Hunt and Symonds 1995), contained some observational data. These were particularly explored in an effort to disprove the emerging analysis or any prior reflexive assumptions. This will be discussed further below.

**Table 4 Iteration of themes and synthesis**

Themes 1 <sup>st</sup> iteration	2 <sup>nd</sup> iteration	Synthesis	Relevant papers
<ol style="list-style-type: none"> <li>1. Interchangeable midwifery staff</li> <li>2. Relationships with colleagues and institution</li> <li>3. Authoritative expertise and experience</li> <li>4. Senior midwives exerting power - midwifery hierarchy</li> <li>5. Disconnection, oppression, guilt and blame</li> <li>6. The bigger picture, valuing efficiency and task completion</li> <li>7. Acceptance and expectation of intervention as normal, status quo</li> <li>8. Get through the work</li> <li>9. Midwifery skills not valued</li> <li>10. Fear of the birthing process, powerlessness</li> </ol>	Power and control	<b>Arc one</b> Getting through the work' and providing an equitable service for all women	Blaaka and Schauer Eri, 2008 Crabtree, 2004 Davies and Iredale, 2006 Hunt and Symonds, 1995 Hunter, 2004, 2005 Hunter, 2003, Hyde and Roche-Reid, 2004 Keating and Fleming, 2009 Kirkham, 1999, Lavender and Chapple, 2004 Porter et al., 2007 Russell, 2007 Shallow, 2001a -d
<ol style="list-style-type: none"> <li>11. Unwritten rules and sanctions</li> <li>12. Junior staff 'sussing out' unwritten rules</li> <li>13. Adaptation to environment, 'fitting in'</li> <li>14. Engineering agreement/ acquiesce to institutional norms</li> <li>15. Acceptance of medicalised environment</li> <li>16. Intervention and technology as normal</li> <li>17. Organisational culture/conformity</li> <li>18. Ethic of service, self-sacrifice</li> <li>19. Avoidance of conflict</li> </ol>	Compliance with cultural norms	<b>Arc two:</b> Enforcing compliance to technocratic norms in order to 'get through the work'	Crabtree, 2004 Davies and Iredale, 2006 Earl and Hunter, 2006 Hunt and Symonds, 1995 Hunter, 2004, 2005 Hunter, 2003 Hyde and Roche-Reid, 2004, Kirkham, 1999 Keating and Fleming, 2009, Lavender and Chapple, 2004, Porter et al., 2007 Russell, 2007, Shallow, 2001 a-d
<ol style="list-style-type: none"> <li>20. Discursive resistance, deviance</li> <li>21. Fibbing and avoidance, subversion, doing good by stealth</li> <li>22. Dissonance, frustration, anger</li> <li>23. Maintaining appearance of compliance</li> <li>24. Valuing midwifery skills, individualised care, relationships with clients,</li> <li>25. Letting birth be, keeping definitions fluid,</li> <li>26. Supporting women through appeal to the 'choice' agenda</li> <li>27. Having the confidence/foresight to avert/manage problems,</li> <li>28. Keeping/returning birth to 'normal'/ Normalising birth</li> <li>29. Protecting women, 'keeping women away from medicalisation'</li> </ol>	Attempting to normalise birth in a medicalised environment	<b>Arc three:</b> Discursive, subversive, and occasional resistance, in an attempt to provide 'real midwifery' for individual women	Blaaka and Schauer Eri, 2008, Crabtree, 2004 Davies and Iredale, 2006 Earl and Hunter, 2006, Hunt and Symonds, 1995 Hunter, 2004, 2005, Hunter, 2003 Hyde and Roche-Reid, 2004 Keating and Fleming, 2009 Lavender and Chapple, 2004 Porter et al., 2007, Russell, 2007 Shallow, 2001 a-d

The quality of the individual studies was rated based on a broad assessment of credibility, transferability, dependability and confirmability (Downe et al 2007). While the quality was generally good, some common flaws were apparent. These included the lack of a theoretical framework and somewhat limited evidence of reflexivity; this may have been due to word limitations of journal publications.

#### **4.9 Themes identified**

Though the midwives were from different areas of practice and different countries, the issues that impacted on their midwifery practice in a hospital setting were surprisingly similar. The following issues dominated their discourse: power and control; compliance with cultural norms; and attempts to normalise birth in a medicalised environment. The participants presented a version of midwifery that some termed ‘real midwifery’. This appears to be an idealised approach to childbirth whereby the woman progresses through labour and birth without any intervention; the midwife facilitates this process actively; and the woman has a positive birth experience. This term was used by one midwife to describe the kind of midwifery that was possible when practice was perceived to be autonomous – in this case, in a small maternity unit (Hunter 2003). Real midwifery appears to be fundamental to midwives’ professional identity. While in the remainder of the studies the term is not articulated, it was often apparent in the discourse of midwives, and appears to be used as a way to differentiate midwives from both obstetricians and nurses. From these studies it appears that ‘real midwifery’ is difficult to achieve in a hospital setting.

##### **4.9.1 Power and control**

The so-called medical model of care, obstetric control and the hegemony of a medicalised system were referred to in all the studies. These were seen as constraints that influenced the midwives’ practice and their use of interventions (Crabtree 2004, Hyde and Roche-Reid 2004, Hunter 2004, 2005). A midwife in one of the Irish studies stated:

*I am very much aware of the power basis and the politics and I have to work within that . . . Obstetricians have a huge influence because of their power*  
(Hyde and Roche-Reid 2004 p. 2619)

Midwives experienced a hierarchical work environment and lacked autonomy in their work but often it was ‘other’ midwives rather than doctors who determined how the midwives practised (Hunt and Symonds 1995, Hunter 2004, 2005).

*You have got somebody up there saying, oh no, you can't do that . . . and that to me is very frustrating* (Hunter 2005 p. 269)

In these studies hospital birth was seen as a clinical event. Apparently of necessity, the midwifery skills that were prioritised were; the ability to actively manage birth in an often busy environment, to be able to use technology and intervention in the care of labouring women and to be able to identify and deal with emergencies. These competencies were more valued than providing a woman centred approach to care or keeping birth interventions at a minimum (Hunt and Symonds 1995, Hunter 2003, Shallow 2001d).

*We are all expected to be able to cannulate, to scrub and to suture perineums<sup>8</sup>.* (Shallow 2001d p. 239)

The potential for litigation was also part of the midwife’s experience.

*(Fear of litigation) certainly does affect people . . . I think if it wasn't for litigation then they would probably not practice in that way.* (Porter et al. 2007 p. 529)

In hospital labour wards midwives were often required to care for a number of women at a time and the heavy workload led them to provide a task-based approach to care (Kirkham 1999, Shallow 2001c, d, Hunter 2003, Hunter 2004, Hyde and Roche-Reid 2004, Lavender and Chapple 2004, Porter et al. 2007).

*it is important to have the woman come in, have her delivered and have her out again . . . getting the job done as quickly as possible* (Hunter 2003 p. 243)

Whether this approach is the influence of nursing on midwifery as suggested by Shallow (2001c), the powerlessness of women and midwives under the medical

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<sup>8</sup> Cannulate refers to inserting an I/V cannula for the administration of intravenous fluids, ‘scrub’ refers to ‘scrubbing’ for caesarean sections or other operative procedures, and ‘suture the perineum’ refers to the need to repair any perineal trauma following a birth.

authority of the hospital system combined with gender politics, as suggested by Kirkham (1999) among others, the exercise of street level bureaucracy as hypothesised in other resource-short public sector settings by Lipsky (2010), the exercise of the Panopticon as proposed by Foucault and his followers (see Arney 1982 for example), or something else is unclear. Nonetheless, many midwives expressed dissatisfaction and frustration with the level of care that they could provide in this environment (Crabtree 2004, Hunter 2003, Hyde and Roche-Reid 2004, Kirkham 1999, Shallow 2001 c, d).

The midwives reported a lack of midwifery leadership and support for normal birth (Hyde and Roche-Reid 2004, Lavender and Chapple 2004) and tended to blame doctors, other midwives and even the women themselves for what is described in all of these studies as the medical model of care. An interesting finding is that even in New Zealand, where midwives practise as lead maternity caregivers with professional and financial autonomy (Hunter 2003, Crabtree 2004), the experiences of these midwives were similar to those of Irish midwives who experience less autonomy as they work in consultant led maternity hospitals (Hyde and Roche-Reid 2004, Keating and Fleming 2009).

#### **4.9.2 Compliance with cultural norms**

Midwives adapted to the practices of the unit even where this differed from their preferred approach to care (Hunt and Symonds 1995, Hunter 2003, Crabtree 2004). The studies indicate that there was a perceived lack of support for normal birth, and midwives were constantly required to meet the needs of the hospital rather than the needs of individual women (Hunt and Symonds 1995, Kirkham 1999, Hyde and Roche-Reid 2004, Hunter 2004, 2005).

*Some of the older midwives trained in the times of technological  
advancements and have forgotten that childbirth is normal*

*(Lavender and Chapple 2004 p. 328)*

With more echoes of Lipsky (2010), midwives complied in order to manage often heavy workloads and provide an equitable service for all women.



*To find enough time for each woman when other women are waiting for you, it is a battle on many days. (Blaaka and Schauer Eri 2008 p. 248)*

Though midwives complained about the so called medicalised approach to care it seemed that other midwives rather than doctors were the main influence on their practice (Kirkham 1999, Crabtree 2004, Hyde and Roche-Reid 2004, Lavender and Chapple 2004, Hunter 2005).

*I am not going to stand here and argue with this woman (midwife) who has been qualified for God knows long – I'm not gonna win.*

*(Hunter 2005 p. 258-259)*

*. . . there is an expectation (by other midwives) that the woman will come in and lie down and be monitored . . . (Crabtree 2004 p. 88)*

Also of importance was the choice or expectation of intervention by women themselves (Hunter 2003, Crabtree 2004); this was sometimes described as an unquestioning passivity and acceptance of the medicalised approach to care (Hyde and Roche-Reid 2004, Porter et al. 2007).

*A lot of women will come in and they don't have a clue and that's you know, quite the way that they want it (Hyde and Roche-Reid 2004 p. 2617)*

Midwives acquiesced to this approach as it appeared to be easier for them to conform than to work against this system (Crabtree 2004, Lavender and Chapple 2004).

*So you go along with this thinking (Crabtree 2004 p. 89)*

According to Shallow (2001c) the medicalised approach to care and the growth in technology has met with little resistance from midwives themselves. Even self-employed midwives in New Zealand were reported to accept medical intervention as a 'normal' part of birth when it occurred in hospital (Hunter 2003, Crabtree 2004, Earl and Hunter 2006). As one midwife stated:

*Midwifery [at the large obstetric hospital] is almost easier, because it is all black and white, and the woman's lying there with her epidural and you are watching the machines (Hunter 2003 p. 241)*

Indeed Sandelowski (2000) hypothesises that the introduction of technocratic maternity care (and, specifically, fetal monitoring) could not have taken place without the ‘retrofitting’ activity of nurses (in this case, obstetric nurses in North America) who, she claims, were pivotal in persuading women to accept such monitoring as a norm.

#### **4.9.3 Attempts to normalise birth in a hospital environment**

A number of midwives experienced divided loyalties between their support for normal birth and a loyalty to their colleagues who had different philosophies of care. These midwives were in a difficult position; their options were to acquiesce to the system, live with the conflict or to rebel against the norms of practice in the hospital labour ward (Hunter 2003, Crabtree 2004, Lavender and Chapple 2004, Hunter 2004, 2005). For some, this led to subterfuge or to occasional resistance, to avoid aspects of medicalised care, even where this may be seen as rebellious by their midwifery colleagues (Hunter 2003, Hunter 2005, Russell, 2007). This can lead to emotional stress for midwives who experienced dissonance, particularly when they were working in an environment where normal birth was not valued (Shallow 2001c, d, Hunter 2004, 2005, Blaaka and Schauer Eri 2008).

*If I as a midwife don't follow the procedure book, I can get into big trouble.*

*You stretch the limits where you see there's a possibility of doing so.*

*(Blaaka and Schauer Eri 2008 p. 6)*

Despite the perception of an oppressive medicalised environment many participants remained committed to normal birth (Hunter 2003, Crabtree 2004, Lavender and Chapple 2004) or at least to normalise birth as much as possible (Hyde and Roche-Reid 2004, Earl and Hunter 2006). This was seen as doing ‘real midwifery’ and in some situations it meant keeping women ‘safe’ from excesses of intervention.

*(I) protected her to have a normal birth, even though it was induced. It could have been a lot worse for her. They would have had monitors and scalp clips and God knows what else*

*(Crabtree 2004 p. 95)*

Midwives reported that normal birth was difficult to achieve in a hospital setting but was more likely to occur at night when doctors and senior midwifery staff were not around (Hunt and Symonds 1995, Hyde and Roche-Reid 2004).

*The best time I enjoy is night duty . . . when you have a one to one with minimum intervention. There's no one popping in to see what's happening and why she isn't making more progress and putting subtle pressure on you*  
(Hyde and Roche-Reid 2004 p. 2619)

Many midwives tried to provide a positive birth experience for women with the minimum of intervention and maintained that it was possible to achieve a normal birth in hospital (Hunter 2003). Others stated that they provided the best care possible under the constraints of the medical system (Hyde and Roche-Reid 2004). It was interesting that midwives had different views of what constitutes normality in childbirth. For some it was 'normal birth but some assistance during the labour' (Crabtree 2004), and the moderate use of technology was also supported (Hyde and Roche-Reid 2004). Intervention was also used by midwives to avoid more interventionist approaches to care:

*I suppose that's a judgement call of when you can sit back and do nothing versus when you get in and do something less minor to prevent the major intervention*  
(Earl and Hunter 2006 p. 22)

Annendale (1988) explored this phenomenon of midwives using interventions that fall within their role to reduce medical referral and interventions. In her study of a freestanding midwifery unit, it is not always clear if interventions were undertaken with the explicit consent of the women concerned. Such practices raise questions of motivation, ethics, and the possibility that the pursuit of normal birth in opposition to medical input may on occasions be undertaken as part of a midwifery professional project, rather than for the explicit good of the individual woman and/or baby.

#### **4.10 Synthesis**

The reality of midwifery practice on a hospital labour wards falls into three broad arcs of activity. These arcs of work are not mutually exclusive.

- ‘Getting through the work’ and providing an equitable service for all women
- Enforcing compliance to technocratic norms in order to ‘get through the work’
- Discursive, subversive, and occasional resistance, in an attempt to provide ‘real midwifery’ for individual women.

These arcs form the following line of argument (Noblit and Hare 1988):

*Midwives who work in a hospital setting strive to provide best care, to get through the work and to provide equitable treatment for the population of women in their care through ensuring or delivering compliance to technocratic norms, and accommodating women’s choice where this did not deviate too far from these norms. Some midwives engage in discursive or subversive practices, and occasionally overt resistance to technocratic norms, in an attempt to provide ‘real midwifery’ for individual women.*

#### **4.11 Discussion**

Eliciting accounts from professionals about their practice might be expected to produce idealised narratives. However, in these studies many of the midwives’ own accounts subvert their stated professional identity as guardians of normal childbirth. The two studies that contained observational data indicate little dissension with these findings. Hunt and Symond’s (1995) work is largely confirmatory of the compliance with cultural norms, but the more recent study by Porter et al. (2007) observed that midwives decision making was generally ‘bureaucratic’ in nature, with an adherence to policies and protocols, rather than negotiating decisions with women. Porter et al. (2007) concluded that, for midwives, there is a tension within the requirements of ‘new professionalism’ which requires that decisions are made in collaboration with clients. They maintain that while midwives support a facilitative woman centred approach in theory this was rarely apparent in their practice. The midwives justified their approach by blaming the environment where they worked, the influence of powerful others (midwives and doctors) and their perception of women’s exceptions of care. This is similar to findings by Crozier et al. (2007) who, from observation of midwives’ use of labour ward technology, classified them as; 'bureaucratic', 'classical

professional' and 'new professional'. A bureaucratic approach was prevalent in how midwives worked.

Blaaka and Schauer (2008) take an alternative approach and describe how experienced labour ward midwives are required to mediate their practice between two different belief systems; a biomedical tradition which is reliant on scientific knowledge and technology and a phenomenological tradition which values the physical, emotional and social wellbeing of women. Midwives move between the biomedical aspects of care while trying to be sensitive to women's needs but there can be a struggle between the two ideological traditions as the midwives learn to accommodate two opposing belief systems. This is similar to what Davis Floyd (2001) describes as 'hybrid' or 'postmodern' midwives who move between traditional and biomedical approaches to childbirth in trying to provide the best outcomes for women and their babies. Similarly, Lane (2002) maintains that few midwives fall completely into either the medical model or the midwifery model of care but could be considered as 'hybrid', changing their practice with experience and adapting to their work setting whether that is private or public hospital, birth centre or home. This was also found in a study by Berg and Dahlberg (2001) who found that where experienced midwives provide care of women who are at high obstetric risk, they seek to normalise the birth as much as possible for the women in their care.

From this metasynthesis, it appears that the way midwives work in hospital is mediated by a 'street level bureaucracy' (Lipsky 2010) in which the actual determinants of midwifery practice are senior midwives and not obstetricians. Street level bureaucrats are those who provide a public service, which involves caring and responsibility. While the nature of this work is allegedly to provide individualised care, the nature of the work setting and institutional imperative makes this difficult to achieve. Clients have no option but to accept the service available. They are encouraged to confide in and trust professionals who are strangers, and to permit themselves to be manipulated in the expectation of fair treatment. Street level bureaucrats use their discretionary authority defensively to manage an otherwise overwhelming workload. The public service is delivered through a system that values detachment and an attempt at equal (not individualised) treatment under conditions of limited resources and constraints. There is as a '*myth of altruism*'

(Lipsky 2010 p. 71). This has resonance with many of the accounts of midwifery practice in the studies included here.

Midwives may have certain myths about themselves. While maintaining that they wish to provide women centred care they appear to practice as if bound by the power dynamics in maternity units which work against them achieving this. There is an acceptance that hospital based maternity care is inevitably based on medical protocols and emerging technology, and that as a consequence midwives accept intervention as a 'normal' part of birth. It is unclear from these studies what the underlying factors for this are. When questioned, midwives tend to blame doctors, other midwives and even the women themselves. This suggests that midwives believe that they cannot take personal responsibility for the care that they provide. This disempowerment influences their practice, even when the factors that are seen to be oppressive are not actually operating. While this suggests a classic Foucauldian operation of the Panopticon (Arney 1982), a more subtle analysis is suggested by a more recent paper that has examined the nature of authenticity in occupational groups undertaking 'emotional work' as part of their activities (Ashman 2008). The author contrasts Heidegger's notion of authenticity, which recognises that individuals are '*responsible for choosing their identity, given their particular situation*' (Ashman, 2008, p. 294) with existential notions of authenticity and bad faith as offered by Sartre. Ashman quotes Sartre (1990) as saying that '*authenticity...consists in having a true and lucid consciousness of the situation, in assuming the responsibilities and risks that it involves, in accepting it in pride or humiliation, sometimes in horror and hate*' (Ashman, 2008 p. 295).

In this analysis, 'bad faith' results when those doing emotion work perform their culturally determined role automatically and in-authentically, without taking responsibility for the choices they make in performing this role. The exercise of bad faith serves to avoid the uncomfortable sense of dissonance, and a potential impetus to make change happen that might arise if these individuals were, instead, to inhabit their role authentically. One of the signs of bad faith is an assertion that the individual has 'no choice' than to behave the way they are doing.

This theoretical framework offers a potential underpinning for the synthesis given above, which could now be reframed theoretically as:

*Seeking to perform 'real midwifery' is perceived by most midwives to be the authentic position of the midwifery profession. Cultural and environmental constraints can restrict the practice of 'real midwifery' in hospital labour wards. In this circumstance, the authentic position is to recognise that there is a range of responses possible, including compliance, and discursive, subversive or overt resistance, and that each of these choices engenders personal responsibility. Bad faith is only evident when midwives assert that only one course of action is possible, and that this is dictated by powerful others and specific cultural and environmental conditions.*

This synthesis both incorporates and moves beyond the data in the individual papers in the review. It offers an initial application of the theoretical position that has been proposed by Ashman (2008) for a range of occupational groups involved in emotional work. In this case, inter-professional differences can be more powerful than the commands of an oppressive 'other'. For some, this reflects a conflict in midwifery philosophies.

The difference in midwifery approach between hospital and community settings is identified in the studies reviewed. While this was not the focus of the metasynthesis, three of the included studies involved midwives who worked in both hospital and community settings. The midwives in these studies revealed that they adapted their practice to accommodate the norms of the hospital environment (Shallow 2001 c-d, Hunter 2003, Crabtree 2004). The potential 'emotional labour' implicit in this need for flexibility has been explored in depth (Hunter 2004, Bewley 2008, Deery 2008, McCourt and Stevens, 2008, Ólafsdóttir, 2008).

From constructing this metasynthesis it appears that, for women accessing publicly funded maternity services, the midwifery care they receive will not just depend on the unit in which they give birth. The services they use may consider the wishes of the woman, but this will be compounded by the midwife's belief system, the workload on the unit, the time of day, and the other midwives and doctors who may be on duty at the time.

#### **4.12 Limitations**

While the focus of this metasynthesis was on midwifery practice in labour ward settings, just three of the studies focused on labour ward midwives. The remaining studies included midwives from a variety of settings, including the labour ward. The discourse tended to focus on labour ward midwifery, though this was often implicit. In addition, studies were included if published in books or journals. While some abstracts were identified from published conference proceedings, if the studies were not sourced in journal or book format they were not included.

The views of the community and independent midwives included in some of these studies may not be typical of hospital based midwives; though it could also be argued that as they also work outside this environment they may have a clearer vision of alternative birth experiences than midwives who are habituated to the system. Crabtree (2004) reported that some of the midwives she interviewed chose independent or community practice because it gave them the opportunity to practice the type of midwifery that they enjoy.

Conducting a metasynthesis is an interpretive process in which “*reality is considered multiple and constructed rather than singular and tangible*” (Sandelowski 1993 p. 3). These findings emerged from a review which contained subjective responses. Alternative interpretations of this data are therefore possible. Sandelowski (2006) suggests that the objectivity required for conducting a metasynthesis emerges from disciplined subjectivity and reflexivity. This metasynthesis has been presented at one national and two international conferences (Czech Midwives Conference, Prague 2008, ICM Triennial Congress, Glasgow 2008) and the findings appeared to resonate for midwives who attended. It has also been reviewed by three of the original researchers who endorsed the conclusions drawn in the published article.

#### **Conclusion**

The objective of this chapter was to explore midwives’ perceptions of hospital midwifery with a particular focus on labour ward practice. From undertaking this metasynthesis I gained a deeper understanding of the constraints on midwives’ autonomy in a hospital setting. The themes that emerged as a common experience of midwives in several countries were ‘power and control’, ‘compliance with cultural



norms' and 'attempting to provide 'real midwifery' for individual women'. The complexity of midwifery practice as constructed into the synthesis highlights issues that confront midwives as they endeavour to provide women centred care. The wider application of authenticity and bad faith were incorporated into this construction.

This work presented in this chapter has informed this study which, as will be seen, sought to further probe the concepts of authenticity and autonomy as it applies to labour ward midwives in order to potentially identify the conditions which may enable them to provide 'real midwifery' for individual women and support normality in childbirth. Phenomenology was selected as an appropriate vector to undertake this research. I hoped that this might potentially lead to an understanding of the lived experiences of midwives, and of the factors which may enable or continue to hinder their efforts to provide 'real midwifery' for individual women within large maternity units.

The methodology selected and justification for its use is outlined in the next chapter.

# CHAPTER 5 THEORETICAL PERSPECTIVE AND METHODOLOGY

## **Introduction**

The metasynthesis reported in Chapter 4 revealed many hospital based midwives experience dissonance between their professional identity and their midwifery practice. The review revealed that at least some midwives caring for women in labour support normal birth and provide ‘real midwifery’ when the opportunity arises. Others comply with the norms of the unit or adopt a medicalised approach to care. This led me to consider how to explore this issue further with labour ward midwives. I therefore sought to explore midwives’ construction of childbirth in a hospital setting and to provide an analysis of the perceptions of, dissonances experienced by, and consequent innovations adopted and resisted as they negotiated ways of facilitating birth through a changing environment.

My enquiry was designed to explore the meaning of authentic midwifery experience for labour ward midwives working in a technocratic environment. The context of the initial enquiry was a busy maternity hospital which was due to close and to be merged with two other maternity units into a large new hospital. This afforded the opportunity to explore with the midwives their experience of midwifery in their existing environment and to complete the study by interviewing midwives following a move to a larger unit which would be a new environment for all staff. I hoped that this would uncover the essential meaning of midwifery for midwives as they adjusted to their new setting. I also decided to explore how midwives act on their environment, how birth practices are disseminated, and whether midwives would introduce innovations in their practice when confronted with a new environment.

This chapter explores some competing paradigms in contemporary research before delineating the constructionist paradigm and the origins of phenomenology. Included is a review of the prevalent modes of inquiry in health and maternity care, and the justification for selecting phenomenology as an appropriate way to move forward to address the issues raised.

## **5.1 Competing paradigms in contemporary research**

Prior to the emergence of post-positivism, positivism was the dominant mode of scientific enquiry (Crotty 1998). From an epistemological perspective, positivists maintain that an independent objective reality exists, that knowledge derives from the senses, and that it is linked to scientific inquiry using observation and experimentation. In this paradigm the social world, like the physical world, is held to be predictable and to be based on the laws of causation. The epistemological stance for this perspective is to approach the subject of inquiry as being essentially knowable. There is a disjunction between the etic (outsider) perspective, the person conducting the investigation and the emic (insider) perspective, the source of the information. The investigator is considered to have expert knowledge and the subject of the inquiry is objectified (Hesse-Biber and Leavy 2004). Methodologies used within a positivist paradigm are usually quantitative and often experimental. Classically, hypotheses are proposed and measurement instruments are designed to be used by what is assumed to be a rational and neutral researcher. The hypotheses are tested using inferential statistics and findings are considered to be 'true' if bias have been controlled or accommodated by statistical analysis.

The limitations associated with positivism led to what later emerged as the post-positivist approach to empirical investigation. This paradigm also assumes that an objective reality exists, but that an understanding of this reality is approximate and imperfect because data collection is inevitably flawed, and the nature of phenomena is intractable (Guba and Lincoln 2004). Methods selected by those working in this paradigm also include hypothesis testing and the use of statistics, but the potential for variance is acknowledged with the use of confidence intervals and statistical significance. In the pursuit of objectivity the limitations of the study are disclosed. Researchers using post-positivist approaches may seek to ascertain the emic or participant viewpoint and may incorporate qualitative methods or other strategies. Post-positivists recognise that scientific research methods are not as completely objective and empirical as previously purported to be (Richardson 2004).

For both these logical-deductive positions, the aim of inquiry is explanation of the world by empirical investigation of objective data. The researcher is the expert on a phenomenon of interest and the findings are considered to be value free due to the

supposedly objective nature of the study. The methods selected are reductionist as researchers seek to establish simple laws of causation which enable prediction of outcomes. Findings are generally presented in isolation from their social context (Sprague and Zimmerman 2004). A critique of this approach is that, while results may reach statistical significance, they may have limited applicability for individual cases (Guba and Lincoln 2004).

In contrast to these logical-deductive positions, alternative approaches emerged from an epistemology of constructionism which presupposes that there can be no objective truth as all meaning and understanding of reality is constructed (Crotty 1998). From this social constructionism emerged which focuses on the social dimension of meaning whereby individuals actively construct meaning through their engagement with others in the world around them. Within social constructionism, individuals are born into a world of meaning which reflects the culture and values of the society in which they live. Knowledge is constructed and transmitted out of human interaction with others. It involves developing an understanding of those constructions about which there is relative consensus (Crotty 1998, Schwandt 1998).

For social constructionists there are multiple interpretations of reality which are not discovered but are constructed by individuals. This includes the pre-understandings of individuals and incorporates an historical, political, economic, cultural and social perspective. Objective reality does not exist and truth cannot be fixed; there are instead multiple truths with interpreters agreeing or disagreeing according to their social, political, cultural and economic perspectives (Crotty 1998). This shared understanding of social reality is mediated through language as it is through language that stories are shared and understood so that meanings and constructs can emerge. In addition, though language is important to shared understandings, language is also interpreted by individuals. As such, meanings can change and be repeatedly reinterpreted (Gegen 2009).

Researchers using a constructionist approach seek to understand the social, political, economic and cultural history that encompasses the phenomenon under investigation (Guba and Lincoln 2004). The approach is inductive and involves interpretation, as researchers seek to establish an understanding of reality that has meaning for individuals. Findings are presented in their social context. Methods used may

include a variety of qualitative and quantitative approaches including interviews, observation, narrative, case study, questionnaires and document analysis (Gregen 2009). From this, knowledge accumulates in a relative sense through the formation of more informed constructions, using an interpretive process as various constructions are brought into juxtaposition.

## **5.2 Post-positivism and its contribution to constructing evidence for health care**

In health science research post-positivist approaches are pre-eminent in the drive to advance knowledge to support the increasing demands for the delivery of evidence based health care (Mayer 2004, Straus et al. 2005). This has served the health sector well and continues to be used to investigate clinical questions within maternity care. Within this paradigm, a hierarchy of evidence is constructed which determines the degree of certainty that can be attributed to the conclusions drawn. Qualitative studies are increasingly used in evidence based guidelines (Tan et al. 2009) but are not generally included in the hierarchy of evidence, which places systematic reviews and randomised controlled trials at the top and expert opinion or consensus at the end (Soltani 2008).

In maternity care, the Cochrane Collaboration Group was one of the first to systematically explore the scientific evidence to guide clinical decision making (Cesario et al. 2002, Enkin et al. 2006). The focus of this collaboration is on undertaking systematic reviews in order to collate evidence to address specific clinical questions. Bias is minimised by using systematic methods and meta-analyses with strict eligibility criteria to determine whether an intervention is effective compared with a control. While high quality randomized trials are central to the approach, the Cochrane Group now accepts that qualitative studies can add value and may facilitate policy development and consumer decision making (Noyes et al. 2008).

There are criticisms of the quality of some Cochrane Reviews (Olsen et al. 2001, Eysenbach and Kummervold 2005) yet the Collaboration continues to produce valuable information which informs clinical practice. The importance of Cochrane reviews are evident in the NICE Guidelines for Intrapartum Care, where from over 600 included studies there are 37 Cochrane Reviews and just eight qualitative studies

(National Institute for Clinical Excellence (NICE) 2007a). In contrast, the NICE Guidelines on antenatal and postnatal mental health include vignettes of women's experiences of mental health derived from qualitative work (NICE 2007b).

The growing evidence agenda in health care has stimulated medical interest in the value of qualitative research (Mays and Pope 2000) and such studies have begun to appear in key obstetric journals (Danerek et al. 2005, Bahl et al. 2009, Doshani et al. 2009).

### **5.3 Theoretical approach**

As has been outlined, positivism and post-positivism which both emphasise the rational and scientific are linked to empirical scientific research methods. This presupposes that there is a reality out there that can be studied and known and findings are considered to be significant and correct. These approaches remove participants from the context of the study and individuality is lost through efforts to standardise participants by pre-defined criteria.

The work involved in conducting the metasynthesis gave me an insight into the experiences of midwives in a hospital environment. While a number of quantitative studies were identified (Sinclair and Gardner 2001, Mead 2008) these served to provide an overview of how midwives experience practice in a more generalised way. For example, Mead (2008) found that midwives working in units with high levels of intervention had a higher perception of risk for intrapartum care than midwives working in units with lower levels of intervention. Sinclair and Garner (2001) reported that while midwives preferred to assist with a non-technological birth they also had an acceptance of technology in their practice. From these studies and the qualitative work uncovered, it is evident that midwives are influenced by the environment in which they work. While they maintain to be advocates for normal birth, in a hospital environment they largely comply with standardised technocratic even interventionist approach to intrapartum care. For this study I hoped to go beyond this and explore midwives' construction of childbirth and midwifery practice through an in-depth exploration of the experiences of labour ward midwives as they changed their work environment. By using an interpretive approach I hoped to avoid a replication of previous studies in the area and yet seek a better understanding of

how midwives construct birth, how they experience the reality of birth, and, as will be evident from this study, how a change in their work environment can impact on their midwifery practice.

A social constructionist perspective was considered appropriate for this study which centres on labour ward midwives' experience of childbirth in a technocratic environment. As was apparent from the metasynthesis in Chapter 4, the context in which midwives work impacts on their practice. The review led me to consider the influence of midwives' life-world, their lived experiences of midwifery, in this environment. Of particular interest was how midwives have adapted to a working in a technocratic environment for birth, yet potentially, try to maintain their professional identity through a philosophy around normal birth.

An opportunity was available to me to study a group of midwives in Ireland as they were undergoing a major change in their work environment. To understand the realities of the midwives' world as they experienced this change and the impact it might have on their practice required a research approach that could accommodate the complexities of their experience. A social constructionist approach was therefore deemed appropriate. This fits in with my own philosophy that sees individuals as unique, self-aware, reflective and capable of perceiving and generating meaning for themselves. Previous studies indicate that midwives do not take responsibility for the type of birth that is prevalent in maternity hospitals (see Chapter 4). I wanted to go beyond a culture of blame and guilt as described by Kirkham (1999) to explore midwives' experience in a different way. While I was not sure that I could get authentic responses from the midwives I would interview, I hoped that the move to a new environment would reveal what was important for the midwives themselves. I wondered if being in an unfamiliar place, physically, socially and emotionally might remove their normal ways of behaving and thus allow space for underlying views and opinions to be voiced.

#### **5.4 The representation of the researcher in qualitative research**

The constructionist researcher is inextricably linked to the research endeavour (Moustakas 1994). Where an interpretive approach is selected the researcher makes decisions at several junctures which impacts on the final analysis, findings and

discussion (Denzin 1998). As a midwife undertaking research on childbirth, my own midwifery experience would inevitably impact on my approach to the study and my interpretation of the findings. Constructionist approaches require representation of the researcher in the study in order to engage authentically with the data and to develop authentic interpretations of how individuals, the research participants, engage with their world.

### **5.5 Constructionism and hermeneutic phenomenology**

It is acknowledged, that constructionism and hermeneutic phenomenology are often intertwined (Crotty 1998). Hermeneutic phenomenology, as a methodology, is based on interpreting meaningful interactions which are explored to ascertain the essence or essential meaning of a phenomenon of interest. While Husserl is credited as being the originator of the current phenomenological movement, Heidegger developed a school of phenomenology which became known as interpretive hermeneutics. Through this he sought to uncover hidden meanings in phenomena which for him were the object of human experience (Crotty 1998). Heidegger believed that understanding is the realisation of *Dasein*, which is being-in-the-world (Gadamer 1979) or as van Manen (1990) explains it refers to the ‘aspect of our humanness which is capable of wondering about its own existence and inquiring into its own Being’ (p. 176). This aspect of Heidegger’s work will be explored below.

While phenomenology is essentially a philosophy, it is increasingly used as a research methodology by those who wish to undertake an interpretive approach to their work (Dowling 2004, Priest 2004). This method of investigation seeks to describe phenomena as experienced in terms of what it means for the person who experiences it. The use of phenomenology as a methodology has been extensively critiqued (Crotty 1996, Paley 1998, Annells 1999) and defended (Burke Draucker 1999, Darbeyshire et al. 1999). This will be further discussed below.

Caelli (2001) highlights that researchers utilising phenomenology find that the method is not greatly developed. Researchers need to clarify certain issues in relation to phenomenology’s philosophical underpinnings and the methodological implications prior to undertaking a study using this approach (Anderson 1991, Burke Draucker 1999, Caelli 2000). The next section presents my interpretation of this



history. In the following chapter the methods used to undertake this study will be described.

### **5.6 Edmund Husserl (1859-1938)**

Husserl advanced the philosophy of phenomenology based initially on the work of Franz Brentano (Moran 2000). His approach emerged from a positivist paradigm and has underlying assumptions of both objectivity and neutrality (Koch 1999). The search for the foundation of knowledge was dominant in his work. Through him, phenomenology became the study of consciousness and human experience (Palmer 2001). For Husserl, there is no consciousness without the world, nor is there a world without consciousness (Palmer, 1988). Nevertheless, the inquiry into and recognition of experience could lead to the ultimate meaning of knowledge (Koch, 1995).

Key ideas in Husserl's exploration of human experience are consciousness, intentionality and phenomenological reduction (Koch 1999, Gorner 2000). Husserl developed Brentano's concept of *intentionality* as an essential component of understanding. This is the principle that every mental act is related to some object (Husserl 1960). When we see something we project a certain set of expectations upon it which are fulfilled, adapted or discarded in our subsequent perceptions (Moran 2000). All thinking, perceiving, imagining, remembering has something as a focus and our perceptions of this have meaning; intentionality is the internal experience of having consciousness of this (Husserl 1960).

Husserl introduced the concept of the *lifeworld*; or lived experience, that which individuals experience pre-reflectively without interpretation. The *lifeworld* is representative of our intentional experiences (Husserl 1976). It is not readily accessible because it constitutes what is taken for granted in daily life. An attempt to understand the *lifeworld* is an attempt to understand the essential features of a phenomenon as free as possible from their cultural context (Dowling 2004).

Fundamental to Husserl's approach was the consideration of experience as the ultimate basis and meaning of knowledge (Koch 1995). For him, the task was to return to the taken for granted experiences and re-examine these in order to bring to light the ultimate structures of consciousness (essences). Thus the researcher using

Husserlian phenomenology enquires into the meaning of human experience. The phenomenon of interest must be understood and described and its essence revealed before explanations are made. This initially requires thick descriptions (Geertz 1994) of the experience, which are then refined through a process of reflection (Dowling 2004). *Bracketing* is an essential feature and requires the researcher to examine and set aside their presuppositions and preconceptions prior to exploring the area of interest. Biases, prejudices and beliefs are held in abeyance; this, Husserl believed, enabled the inquirer to maintain objectivity. Another component of Husserl's phenomenology is the process of *reduction*. In phenomenological reduction the theoretical or scientific conceptions that overlay the phenomenon being studied, and which prevents one from seeing the phenomenon in a non-abstracting manner, are stripped away (van Manen 1990). Phenomenological *intuiting* is at the heart of phenomenological reduction (Dowling 2004). This is the eidetic understanding of what is meant in the description of the phenomenon; an effort to get to know and understand the phenomenon as it shows itself when described by others (Demeterio 2001). When this is achieved, it is supposed that the essential features of the phenomenon will be revealed as free and as unprejudiced as possible.

### **5.7 Martin Heidegger (1889-1976)**

Heidegger moved away from trying to develop an understanding of the world which required bracketing of presuppositions, phenomenological reduction and description. He maintained that Husserl's approach was hampered by a search for certainty and truth, and that this led him to miss important features of the original subject matter being investigated (Moran 2000). He advocated the ontological view that the lived experience is an interpretive process and this must be incorporated into any understanding of phenomena (Racher and Robinson 2003). *Being* rather than consciousness or subjectivity is the focus of Heidegger's work. Rather than discarding Husserl's theme of intentionality, Heidegger maintained that an understanding of *Being* is what makes intentionality possible (Gorner 2000). Meaning is sought through interpretation and it is for this reason that he linked phenomenology with hermeneutics, a term originally applied to the exploration and interpretation of biblical texts. Heidegger maintained that phenomena always require interpretation to reveal their essential meaning.

While I have read Heidegger's seminal work *Being and Time* (first published in 1927) in translation (Heidegger 1967), without a background in philosophy this work presents considerable challenges. To gain a comprehensive understanding would require an in-depth knowledge of philosophers and philosophical thinking stretching back to Aristotle, Plato and Socrates. As a result this section is largely based on the writing of others who have provided me with an understanding of Heidegger's interpretive approach. This is drawn principally from the work of Crotty (1998), Moran (2000) and Gorner (2010).

These writers maintain that Heidegger was particularly important because he developed phenomenology as an ontology. Heidegger argued that we live our lives through our experience of the world and not principally by knowing it. Hermeneutic phenomenology became an enquiry into the manner and structures of Being (for this he used the German word *Sein*). For him Being or presence in the world was a universal concept. Thus, understanding was no longer considered 'as a way of knowing, but as a mode of being, as a fundamental characteristic of our 'being' in the world' (Koch 1995 p. 831). This Being is revealed using the structures of human existence. Heidegger made the exploration of the 'question of Being' and the 'question of the meaning of Being' as his life's work. He maintained that Being, while obvious to all, does not indicate 'what is Being' or what it signifies. Being knows itself only in relation to others (Heidegger 1967). Hermeneutic phenomenology therefore became a method of interpretation that directs the investigator to an understanding of Being.

According to Heidegger, in daily life humans live in inauthentic tradition and habituation (Moran 2000 p. 226). His life's work engaged into inquiry into day to day existence with the purpose of raising this existence to a more authentic level. For him, how things appear must be studied as they essentially present themselves while also considering that they are self-concealing. Through this method of inquiry he sought to search for a genuine self and also an authentic life among others.

Heidegger introduced the concept of 'Being there' or Being-in-the world' (*Dasein*) to explore this further. *Dasein* is explained by Moran (2000) as follows:

*It names human being in so far as it is individualised as myself or someone else and in so far as questioning is its essential mode of relating to Being. Dasein then specifically picks out our individual possession of our existence and the fact that it is a question for us, a question which concerns the nature of Being as such . . . Dasein refers to the specific mode of Being of humans, emphasising its individuality and its role in the disclosure of Being. (p. 238)*

Thus to understand *Dasein*, is to understand the nature or the meaning of phenomenon. It includes an authentic awareness of one's being, a belonging to the world, and an availability and use of the world while being related to others. Heidegger's use of the term *Dasein* is not directly linked to entities such as people or things, rather it is something that 'is found *only* in social, historical matrices' (Scott 1993 p. 70).

As far as *Dasein* is concerned, to be is to understand. Access to *Dasein* comes through enquiry into human existence. In understanding, *Dasein* projects itself on to the possibilities of its being. *Dasein* includes the past (access to memory), being (in the present), and future (a sense of anticipation) (Gorner 2000 p. 141). To understand *Dasein*, is to be alert to the kind of situation that gives rise to that question or issues that covers it up. It is only through disclosure and revelation that what is hidden by how things appear in their everydayness can become manifest. This challenges us, but also enables us to be open, to encounter it authentically while being less caught up with other concerns (Heidegger 1962). For Heidegger, *Dasein* is most true when it is revealed; it is the possibility that is open to all values and meanings, and yet stands out from everything that makes an individual's life worth living.

To understand this involves recognising that, for the most part, humans live their lives wrapped up in moods and practicalities of everyday life. In order to deal with life's difficulties humans have an inherent tendency to make things easier where possible. Heidegger (1962) describes this as the 'falling' of *Dasein*. All assertions and judgements taken by individuals are taken against a background of prejudices and pre-judgements, which mostly are not explicitly expressed. In addition, human encounters and experiences are interpreted by what has previously been interpreted

both by ourselves and also by others. Understanding therefore operates from a common consensus and while this is often not expressed, it becomes apparent by the way we relate to things. This Heidegger considers as an inauthentic kind of awareness.

In the quest for authenticity, Heidegger stressed the importance of thoughtful questioning, described as 'looking for the thoughts behind our thoughts' (Moran 2000 p. 246). For him, asserting and questioning are important methods for disclosure but he warned that attention also needs to be paid to the nature of questioning itself (Heidegger 1962). He considered that questions do not arise in a vacuum but carry presumptions and pre-judgements which will govern the enquiry, how the question are asked and will also predetermine to a certain extent what will be discovered. Presupposing is an attempt to explore and consider questions beforehand and can lead to greater pre-understanding. This and the mode of access are crucial to both the questioning and the answer and ultimately the achievement of understanding.

Heidegger brought the essential role of humans as questioning beings to an ontological level and considered that it is this that essentially marks out all human existence (Moran 2000). His later work provides an insight into a future where he foretold that the encompassing nature of technology would have the potential to engulf genuinely human modes of existence (Moran 2000).

### **5.7.1 Hermeneutic Circle**

Heidegger (1962) considered that the interpretation of human existence is always changing and an understanding of this considers what is already understood and takes account of the historicity of both of human nature and of the enquirer. Understanding emerges from a development of what is already understood, with the more developed understanding returning to illuminate and enlarge one's starting point (Crotty 1998 p. 92). This experience of moving dialectically between the part and the whole became known as the hermeneutic circle (Koch 1995, 1996). This circle and search for understanding is not closed, constrained by presuppositions but moves backwards and forwards between the existence to be examined and the nature of the individual. It remains open to new possibilities (Moran 2000). This reciprocal

activity exists as a place between pre-understanding and understanding (van Manen 1990) and from this understanding (*verstehen*) can emerge.

### **5.8 Hans-Georg Gadamer (1900-2002)**

Gadamer saw philosophy as a living and participative activity. Like Heidegger he was concerned with describing the process by which understanding and meaning can emerge. He considered that hermeneutics was an on-going process, rooted in human finiteness and language, which was never quite complete. Understanding becomes the essential manner of being-in-the-world with language as the medium through which human experience can be understood (Gadamer 1979).

Gadamer's model of understanding emerges from conversation or dialogue where there is an open exchange of ideas that seeks or leads to agreement about some matter. A condition of genuine understanding is that we accept the good intentions of a person whom we are seeking to understand, are open to new possibilities and to the truth of the other's position, while, at the same time, remaining true to our own starting point, our '*inherited outlook and presuppositions*' (Moran 2000 p. 252). This form of authentic conversation does not have a predictable outcome and is not under the control of either individual, but is determined by the matter at hand. All understanding is interpretative and, as interpretation involves an exchange between the familiar and the alien, so interpretation is translative, and leads to uncovering something new (Malpas 2008).

Understanding is linguistically mediated. It comes because of language and in language; it is where our mode of being in the world comes to realisation (Gadamer 1975). For Gadamer, language does not just reflect human being but is a factor in making humans be, it involves others, just as it involves the world, and it brings about human existence as a communal understanding (Moran 2000). While language is an essential component of our experience of the world it is not neutral. It is affected by the value system of the culture and educational tradition that supports it.

Like Heidegger, pre-understanding was important for Gadamer (1979). He maintained that through language we reveal our assumptions and traditions. Truth requires an exploration of what is spoken in the unspoken; it is simultaneously both revealing and concealing. Without engagement and being open to new

understanding we remain trapped within subjective viewpoints and traditions. Gadamer's (1976) hermeneutics is a way to be open both to ourselves and to an understanding of the other and is described as a 'fusion of horizons'. He maintained that to understand does not mean that an individual understands better but rather that the individual understands in a different way. Gadamer affirms the position of the researcher in the hermeneutic circle which he presents as emerging from a 'fusion of horizons' and is an essential part of understanding itself (Gorner 2000).

In this circularity, what gets understood is already anticipated in what one expects to be understood. The attempt to authentically understand the other begins with the recognition that we are separated by different horizons of understanding. Mutual understanding can come through overlapping consensus, the merging of different horizons, rather than through the abandonment of initial understanding (Moran 2000). Conversation or dialogue leads to a journey of discovery; bringing pre-suppositions to light and exploring a concept or phenomena in the context of acceptance and trust. Gadamer's hermeneutics is one of trust and openness rather than domination or suspicion.

For Gadamer understanding has a practical orientation in the sense of being determined by our contemporary situation. He engaged in reflection on a range of contemporary issues including the nature and role of modern science and technology (Gadamer 1976, 1998).

### **5.9 Utilising hermeneutics as a research approach**

While Husserl, Heidegger and Gadamer did not develop phenomenology as a methodology, their approach has been widely used to underpin certain types of qualitative research (Fleming et al. 2003, Hammersley 2007). Koch (1996) maintains that the application of hermeneutic understanding of texts through language can be useful for a search to understanding within healthcare environments. The terms phenomenology, interpretive phenomenology and hermeneutics are sometimes used interchangeably which has resulted in multiple and sometimes confusing interpretations in the literature. Fleming et al (2003) suggest that some of the difficulties experienced by researchers are that they rely on translated sources of original German texts. As I am not proficient to be able to read the texts in German,

I acknowledge the limitations in my selection of this approach, which is informed by those who translate and therefore interpret the work of the original authors.

For researchers, interpretation and understanding comes from events, data collection, analysis, and interests whereby meaning and significance can be gained. This comes from an on-going and varied process of engaging with the data, which may include the structure of the text, observation, reading, listening, reflecting and writing. Both the researcher and participant are self-interpreting but analysis is held in abeyance throughout this process. Understanding emerges through a 'fusion of horizons' between the pre-understandings of the researcher, the research process, the sources of information and the interpretative framework used (Koch 1995). Through reflection, understandings are made rather than found.

Fusion of understanding is achieved by the coming together of different vantage points, thus the phenomenological researcher must remain open to the standpoint and experience of the other. Researchers must be aware of their own pre-suppositions, tolerate ambiguity and uncertainty and be open to new understandings. Using Gadamer (1976 p. xxi) as a guide, genuine questions define true dialogue which leads to several possible directions and to several possible answers. Dialogue must be open and non-directive to enable participants to follow their own direction. During the course of this study I endeavoured to consistently engage with the hermeneutic circle in order to gain an understanding of the midwives' experience. Throughout the period of data collection and analysis, constant and repeated reflection was required to consider and critique the data. It was only through this process that a fusion of horizons could be achieved. Further details of this process are provided in Chapter 6 and a final account of my reflective journey throughout this study is provided in Chapter 16.

Crotty (1996) maintains that nursing phenomenology does not sufficiently adopt the epistemological situation regarded by Husserl as essential to phenomenology. Similarly, Priest (2002) maintains that researchers do not often acknowledge that reality and experience are deemed to be socially constructed, and that any particular interpretation represents one of many possible truths rather than a single absolute truth (as believed by Husserl). Paley (1998) suggests that nurses misuse Heideggerian phenomenology by using methodologies from nursing literature which



are inconsistent with this. Caelli (2000) rebuts these critiques, and contrasts the differences between traditional phenomenology, which focused on abstract concepts such as 'being' or 'consciousness', with developments in American phenomenology which are focused on reflected experiences in an attempt to gain understanding in a way that is meaningful, particularly for researchers in health sciences. Midwives' use of phenomenology has not been identified as problematic, and throughout this study, I have endeavoured to accurately reflect the origins of phenomenology.

### **5.10 Gaining understanding through the analysis of interview data**

Gadamer suggested that a systematic approach is required for phenomenological research but did not offer a methodology to guide researchers. In fact, he rejected the idea that applying rules could lead to better understanding (Gadamer 1996). van Manen, who is used extensively by those who undertake an hermeneutic approach, acknowledges the difficulties experienced by researchers. He accepts that phenomenological texts of interest to professional practitioners differ from other social science texts which engage in more theoretical and philosophical phenomenology. While phenomenological researchers in general use a variety of data sources such as poetry, art, literature and dialogue, in the health sciences, data are more usually obtained from interviews with those who may provide an insight to the phenomena of interest.

To analyse findings, van Manen (1990) maintains that phenomenological researchers require an approach which facilitates reflection and interpretation and ultimately leads to an understanding of the phenomenon of interest. He suggests the following steps; turning to the nature of the lived experience, investigating the experience as we live it and hermeneutic phenomenological reflection and phenomenological writing. Fleming et al (2003) noted that these steps are largely consistent with the work of Gadamer, but that there are some differences, such as in their consideration of the role and value of pre-understanding. For both, understanding implies an investigation into ones pre-understanding. van Manen suggested that this should be turned against itself to reveal its shallow or concealing character, whereas Gadamer has a more positive view. For him, the value of identifying and reflecting on one's pre-understandings enables the researcher to enter the hermeneutic circle to engage

authentically with the nature of the inquiry. Pre-understanding is revisited time and time again.

Although Gadamer stresses the importance of the dialogue over the written text, in qualitative research it is usual for interviews to be transcribed. In analysing these, the researcher must read texts while listening to the words in order to create a common understanding with the participant (Gadamer 1996). Text can include reflections on the interview and the observations of the researcher. Non-verbal expressions also influence understanding. Analysis of conversations should occur within the hermeneutic rule, moving from the whole to the part and back to the whole (Gadamer 1990).

Fleming et al's (2003) method draws directly from Gadamer's hermeneutic phenomenology. This consists of five stages; the first is to decide on the research question which must be consistent with a hermeneutic approach, i.e. to gain a deep understanding of a phenomenon of interest. This is followed by an exploration and identification of the researcher's pre-understandings through reflection and confrontation with different belief systems. This process should enable the researcher to transcend their own horizon. Following this is the period of data collection whereby the researcher seeks to gain understanding through dialogue with participants. During this stage, researchers must remain open to the experiences of the other and it is through dialogue and language, using open conversation the researcher finds ways of developing a deeper understanding of the phenomenon of interest. A new understanding ultimately emerges through a fusion of horizons between the researcher and participant.

Analysis for both van Manen and Fleming involves examining interview texts to find an expression that reflects the fundamental meaning or understanding of the text as a whole. The starting point for this will influence the meaning of the whole and facilitate an understanding of every other part of the text. This first encounter with the text is influenced by a sense of anticipation, which has developed through the pre-understanding of the researcher. In the next phase every sentence or section is investigated to expose its meaning for understanding of the subject matter. This stage will facilitate the identification of themes, which in turn should lead to a rich and detailed understanding of the phenomenon under investigation. These themes

are then challenged by, and in turn, challenge the researcher's pre-understandings. Every sentence or section of the text is then related to the meaning of the whole text and with it, the sense of the text as a whole is expanded. This is the significance of expansion of the unity of the understood sense (Gadamer 1990). Heidegger and Gadamer maintained that understanding is not possible without pre-understandings but for Gadamer, pre-understandings are repeatedly reflected upon so that a fusion of understanding can be achieved.

For Gadamer, the hermeneutic circle is only fully experienced by the movement forwards and backwards, with this comes an expanded understanding of the whole text, and the meaning of individual parts can widen. For Fleming, the final step involves the identification of passages that seem to be representative of the shared understandings between the researcher and participants. Such passages should give an insight into that aspect of the phenomenon being discussed.

Feedback to participants should then be provided and should precede further discussion in order to facilitate a shared understanding and complete the hermeneutic circle. The researcher, however, must take responsibility for the final interpretation (Fleming et al. 2003). The whole process could go on indefinitely as every understanding will change as time goes on. However, a decision normally based on time or resources will be taken on the number of times the cycle is repeated (Fleming et al 2003).

### **5.11 Identification of pre-understandings**

Gadamer maintains that pre-understandings and prejudices need to be provoked in order to be realisable. It is therefore appropriate at this stage to present my perspective as I commenced this work. When I worked as a practising midwife I developed a belief that many women were misinformed about their ability to give birth without the need for intervention, monitoring and surveillance. For women to have confidence in birth requires midwives to also believe in normal childbirth in order to support women throughout this process. When working as a labour ward midwife in an obstetric led unit, there was a perception that we, as midwives did not expect to be accountable for the care women received. I empathised with the experiences of the midwives cited in the Lourdes Report (Chapter 3) who were

caught in a situation where they accepted poor obstetric practice, or felt powerless to do anything about it.

It has been several years since I have worked in a labour ward but I have never been far from that environment due to my involvement in the education of midwives. I came to this study with a belief that normality of childbirth is not just a difference between the approach of midwives and obstetricians over what has been termed the medicalisation of childbirth, but that the changing environment for childbirth largely reflects changes in society; midwives, doctors and women are all involved. A concern for me as a midwife educator was that, although many students entered a midwifery programme with the impression that pregnancy and birth were normal life events, they often exited with a cautious, risk-averse approach to labour because of their experience in clinical settings. I was particularly concerned when some students stated that they had never seen a 'normal birth'.

In undertaking this study I have developed a more open understanding of the complexities that surround childbirth and maternity care. While the literature berates the medicalisation of childbirth and some authors take a feminist approach, the challenges posed by this study has helped me to be more open to the issues that emerged from the participants.

In analysing the dialogue of the midwives, I encountered the lived experience of these midwives as it was revealed to me at the time. This confrontation with different beliefs and experiences, such as they were revealed, has helped me to reflect on my pre-suppositions. This has enabled me to conduct these interviews and analyse the results with what I hope is an open mind to new and different understandings.

## **Conclusion**

The intention of this study was not just to expand my understanding of midwives' experience of caring for women in labour and birth in a hospital environment, but also to come to an understanding of the authentic meaning of this experience using a phenomenological perspective. This chapter has put forward my understanding of phenomenology as a methodology and the ontological basis for this. The chapter has explored the competing paradigms in contemporary research, including the

constructionist paradigm and the origins of phenomenology. Included is a review of the prevalent modes of inquiry in health care and the justification for selecting phenomenology as an appropriate methodology for this study. The phenomenology of Husserl, Heidegger and Gadamer were briefly explored and a review of hermeneutic phenomenology as a research approach drawing largely from the work of van Manen and Fleming.

In the drive for evidence based health care qualitative methodologies do not feature strongly and are often misunderstood. By selecting an interpretive phenomenological approach for this study, based largely of the work of Heidegger and Gadamer, I hoped to develop an understanding of the meaning of midwifery practice in a large busy labour ward and the apparent paradox whereby hospital based midwives purport to support normal birth but often practice in an environment where intervention is the norm. This investigation would not be feasible using an alternative approach.

Conducting the interviews involved a phenomenological approach in order to engage with the essential meaning of midwives practice for these midwives. As will be explored further in the next chapter, data analysis involved constant comparison and reflection on the data collected in this study based largely on the approach of van Manen and Fleming.

The next chapter will provide details of the methods and analytic strategies used in undertaking this study.

## SECTION 2 FIRST STAGE OF DATA COLLECTION

### CHAPTER 6 METHODS PHASE I

#### **Introduction**

The previous chapter provided a description and justification for the epistemological and theoretical foundation for this study. The philosophies of Edmund Husserl, Martin Heidegger and Hans-Georg Gadamer were outlined, together with the justification for selecting social constructionism as an epistemological approach within the health and social sciences. This chapter describes the methods used to conduct the study with a particular focus on Phase I, which consisted of interviews with six labour ward midwives to explore their personal experiences of midwifery. The specific methods used for Phase II are provided in Chapter 8. To avoid repetition later, the ethical issues, data management and analysis sections which are relevant to both phases of the study are addressed here.

In commencing this work it is important to acknowledge that each midwife will have their own perspective of childbirth from their individual life experiences. Hermeneutic phenomenology based on the work of Heidegger and Gadamer provided an appropriate theoretical framework to initially approach this study and provided me with an approach to data collection and initial understanding of midwifery practice of labour ward midwives that accepted the importance of context and individual specific experiences. In using this approach contemporary midwifery practice could be explored as it is lived. As will be addressed later in this thesis, during the second period of data analysis, the work of Merleau-Ponty emerged as a useful framework for exploring the experience of midwives in the new maternity hospital. Details of Merleau-Ponty's work are provided in Chapter 15.

#### **6.1 Study design**

This study was undertaken in two phases. The first involved interviewing labour ward midwives working in a maternity hospital scheduled to close. Through these interviews I sought to ascertain the experience and established practices among the midwives. I hoped to explore with them how they constructed birth in an established

maternity hospital and how they accommodated their practice to the environment. The hospital was due to amalgamate services with two other maternity units into a large newly built hospital six months later. This chapter provides an account of the methods used to collect data for this, the first phase of the study. The second phase was undertaken one year after the opening of the new much larger hospital.

## **6.2 Setting for Phase I**

In all there were four maternity hospitals or units involved in this study. The three amalgamating hospitals are labelled as, Hospital A, a stand-alone public maternity hospital with over 3,000 births per year, Hospital B, its' sister maternity unit with approximately 2,000 births per year, and Hospital C, a private maternity unit with 1,500 births per year. Hospital A was selected for the site for the first phase of data collection as this was the largest hospital in the region. Details of this hospital will now be provided. The new hospital is named as Hospital D and Chapter 8 provides the details of this setting.

Hospital A was an obstetric led unit which served women from a wide geographical area and offered the standard mix of public and private maternity care. The majority of women attending public hospital antenatal clinics met doctors at each visit. Women who opted for private care received their antenatal care from a consultant obstetrician who attended for the birth of the baby. This gave the pregnant woman assurance that, if she required medical intervention or assistance for the birth, a consultant obstetrician would be directly involved in her care.

While some midwifery clinics were available, these midwives did not provide continuity of care for the women when they went into labour. As stated in Chapter 3, continuity of carer or midwifery led care are not features of the maternity service in Ireland.

The history of this hospital dated back to 1799. The labour ward, which was built in 1963, consisted of three rooms for women to give birth. Each contained two labour ward beds separated by a curtain (Appendix 2). Two of the rooms were interconnected by a shared sluice room and a toilet, the third room was linked to the obstetric theatre though another sluice room. A second theatre and recovery room completed the areas that the women accessed. The midwives assisted at caesarean

sections and other obstetric procedures as required. As was the norm in Ireland at this time, all midwives had a prior nursing qualification.

Between August and September 2006 I interviewed six labour ward midwives from this unit. At the time plans were well underway to close the hospital and transfer services to a new site which would be the amalgamation of two public and one private maternity hospital.

### **6.3 Ethical approval**

Ethical approval for this, the first phase of the study, was sought in February 2006. This was obtained from the local Clinical Research Ethics Committee (CREC) and the Faculty of Health Ethics Committee (FHEC), University of Central Lancashire. The local CREC is approved in Ireland under the European Communities (Clinical Trials on Medicinal Products for Human Use) Regulations 2004. Ethical approval was obtained from this committee without delay. The FHEC granted approval in July 2006 following submission of a participant information sheet and consent form (Appendix 3).

### **6.4 Negotiating access**

To obtain permission to access the labour ward midwives a completed Research Application Form was taken by the Director of Midwifery to the management team. Approval was granted. Following this, the Clinical Midwife Managers (CMMs)<sup>9</sup> in the Labour Ward were approached for permission to place a notice in the unit (Appendix 4). During this period there were opportunities to meet with midwives to assess their interest in participating. I informed them that I wished to interview them about 'their experiences of working in the unit' and provided them the information sheet about the study (Appendix 5).

As a midwife educator I was known to many of the midwives; I had worked in clinical practice with a few and others had been students of mine. Access to the unit was unproblematic and most of the midwives, even those I did not know were

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<sup>9</sup> Clinical Midwife Managers are graded as CMM 1, CMM 2 and CMM 3. For each shift a CMM 2 or CMM 1 is the senior midwife in charge of the labour ward. In the larger hospital (Hospital D), a CMM 3 was appointed for the area who was responsible for management of Labour Ward and theatre services.



friendly and willing to talk to me about my study. Some were clearly less interested and seemed to avoid me. It was apparent that they did not wish to be involved. Participants were all self-selecting and completed the Consent Form prior to the interview (Appendix 6).

### **6.5 Sample Phase I**

Purposive sampling was undertaken to select participants with a diversity of experiences. I wished to include senior and junior midwives, and also those who had worked in other units. To ensure that they were sufficiently familiar with the practices in the labour ward I required participants to have at least six months experience and work for a minimum of 24 hours per week.

I provided information on the study to all labour ward midwives encountered during my visits. It was not difficult to find midwives who were willing to be interviewed with the diversity of experience that I required. Of the six midwives selected, three had worked in other maternity units. Two had less than five years' experience and were considered 'junior'; the remainder had 12 – 18 years of experience, much of this within this particular labour ward (Appendix 7). I stopped recruiting following these six interviews as the data I received had provided me with an insight into the essence of midwives' experience of working in this unit.

Interviews were arranged at the convenience of the individual midwife. While my preference was to meet the midwives away from their work environment, this was possible for just three of the staff. The remaining midwives requested that I interview them while they were on duty. This depended on if they could take a break from their work at the prearranged time. These interviews were undertaken with the permission of the midwifery manager on duty in a room off the labour ward where disruptions could be avoided. There were occasions when an interview was scheduled but the unit was busy and it was not always possible to reschedule. The other three interviews took place in a meeting room in the university where I work. This was convenient for participants who preferred this option rather than arranging to meet up in their or in my home.

## 6.6 Data collection

An interview schedule was drawn up to guide the interviews (Appendix 8). Little preparation was required as the midwives had read the information sheet and seemed to be comfortable talking to me about their work. The interviews took about one hour or less and there was time for discussion when the recorder was turned off.

The midwives were asked about what midwifery meant to them and about their experience in providing care for labouring women in the unit which the midwives themselves described as a busy medicalised unit. The interviews were largely conversational and varied depending on the individual and the responses received. At the beginning of the interview the respondent was invited to talk about their experience of working in the unit. While I tried not to raise specific questions and to encourage the respondent to present their own views and stay close to lived experience, certain probes were used to explore issues that were relevant to the study such what the midwife thought about the use of artificial rupture of membranes (ARM)<sup>10</sup> or epidural analgesia.

As a novice to conducting interviews, the subsequent listening and transcribing of the interviews indicated that I had been more directed in my questioning than I had intended. This was useful knowledge and helped me to improve my technique for the interviews in Phase II.

The interviews were recorded electronically using a small digital voice recorder. Following each interview I completed field notes to capture any discussion I had with the midwife and also my immediate reflections on the experience. The electronic recordings were transferred to a computer as soon as possible and deleted from the recorder.

I transcribed these interviews myself which involved many hours of listening to each recording and reflecting on all that was said. Pseudonyms were substituted for the names of any individuals. Further reflective notes were taken and preliminary analysis was undertaken in preparation for Phase II. Findings from Phase I are presented in the next chapter.

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<sup>10</sup> Amniotomy or artificial rupture of membranes (ARM) is a procedure undertaken to rupture the amniotic sac. This is usually performed to induce or accelerate labour.

## **6.7 Ethical considerations**

Ethical issues are ever present in phenomenological research because this methodology involves a personal engagement with the lived experiences of individuals (Usher and Holmes 1997). The researcher must consider the in-depth nature of the engagement and the rights and welfare of the participants. With this methodology there is potential that personal traits and experiences are revealed which may not be in the best interests of the individual. Throughout this study the four key ethical principles of beneficence, non-maleficence, autonomy, and justice (Beauchamp and Childress 2009) were maintained and the rights of individuals protected.

Beneficence refers to an obligation to contribute to the welfare and benefit of others and assist them with their legitimate concerns (Beauchamp and Childress 2009) and is a fundamental principle of ethical research (Polit and Beck 2004). It was not evident that any benefit would accrue to the individual midwives interviewed and they shared their stories and experiences without any expectation of reward or benefit. It was reassuring that the midwives so freely gave me their time and also appeared to enjoy the opportunity to talk about their practice. Many spent time chatting once the interview was complete and the recorder switched off.

Ethical research must balance beneficence with non-maleficence which asserts an obligation not to intentionally inflict harm (Dickenson et al. 2001). It was not anticipated that the interviews would cause distress. Apart from one midwife who withdrew her consent following the interview, other midwives commented that they enjoyed the experience and valued the opportunity to reflect and discuss their work. The interviews did not cause any obvious distress and when the recorder was turned off opportunities were provided to the midwives to discuss the interview and their feelings about it.

A third key ethical principle is autonomy. The participant must be facilitated to act or respond freely and choose to participate at a level where they are comfortable. Autonomy can also be considered in relation to the capacity of the individual to act intentionally and with understanding (Beauchamp and Childress 2009). This principle was considered in preparing the information sheet (Appendix 5) and

consent form (Appendix 6). Information provided on these forms was unambiguous and reflected the focus of the interview. All midwives who participated in the study were voluntary and were aware they could participate or withdraw at any stage. Once the information about the research was provided, it was the midwife's decision to contact me. This was usually when I next met them on the unit though a few did contact me by phone or text message. Signed consent forms were obtained.

A particular consideration prior to undertaking the interviews was that participants would potentially be known to me and that this may influence both their decision to be involved and the information that they would provide. Though I have worked in midwifery education for several years, I had not taught the management of women in labour for many years, thus my involvement with labour ward staff was restricted to occasionally visiting midwifery students. Nevertheless, participants may have agreed to be involved because I was a familiar figure within the maternity hospital.

At the time of doing the interviews this did not seem to be an issue and I had many volunteers willing to participate. The midwives spoke freely and conversations were relaxed. The midwives' conversations were spontaneous and required little additional input once a question was asked. I was somewhat concerned that the everyday nature of the data was, in terms of Heidegger, 'inauthentic'. Midwives described what they did and why, but it was not always clear what their feelings were about their activities. As will be seen, the data from this phase of the study resonated with the findings of the metasynthesis and further probing for greater depth did not reveal different issues. It occurred to me that health professionals are required to manage their emotions in their work, particularly in their communication with others. This may have impacted on the midwives' ability to express their feelings about their experiences and practices. It was interesting that in the second stage of data collection, the feelings of the midwives were more apparent from their dialogue. This will be explored in the findings.

Justice involves fairness to participants. At a minimum this requires that individuals are treated equally without favour or bias (Beauchamp and Childress 2009). This also involves a fair selection of participants, the requirement to protect the identities and also the confidentiality of any data (Usher and Holmes 1997).

All midwives were provided with the same information about the study. While sampling was purposive, I was not selective in the midwives I approached other than to ensure that I met midwives with the diversity of experiences I required. I valued all the contributions made, particularly from those midwives who gave up their personal time to be interviewed. As there was no personal benefit to participants it was reassuring that many of them related that it was a positive experience. They were informed of the purpose of the study and how the findings would be disseminated. Transcripts were available to them to review.

I gave a commitment that anonymity and confidentiality would be maintained. To comply with this, the privacy of the midwives was maintained during my visits to the unit and to ensure that identifying information would not be retained, participants selected pseudonyms which were used in transcribing the data. All electronic recordings and transcriptions were password protected and paper copies of transcripts kept to a minimum. These were available only to my supervisors.

The hospitals where the study took place are also not identified. However, it must be acknowledged that those familiar with the Irish maternity services are likely to identify the new maternity hospital as it opened with considerable publicity and as a consequence the first hospital may also become apparent to some.

### **6.8 Ethical issues in phenomenological research**

When using a Heideggerian approach the researcher cannot be detached from their pre-understandings (Haggman-Laitila 1999). While the language the person uses is being analysed, the meanings of the expression and the content of the experience are important. This requires interpretation based on the existing understanding of the researcher. My familiarity with the midwives and the environment where they worked enabled an ease in conducting the interviews. This became a challenge in the analysis and interpretation of the data. To ensure that I was open to the experience of the midwives required reflection on my pre-suppositions. This involved an engagement with the hermeneutic circle which was achieved by constant questioning of my understanding and interpretation of the data.

These initial interviews were conducted at the time the metasynthesis was developing and a synthesis emerging (Chapter 4). I thus found that when I came to analyse this

data that within this hermeneutic circle, I had to reflect on and consider the interview data, my own midwifery knowledge and experiences and the experiences that were being uncovered from midwives and researchers as I continued to draw my conclusions to the metasynthesis. As stated earlier, and will be apparent in the next chapter, the findings from this set of interviews are not dissimilar to the findings from the studies reviewed in conducting the metasynthesis. At the time, I questioned my ability to be open to new understandings, but, as will be seen, the experiences of these midwives were consistent with the experiences of other midwives working in a similar environment.

## **6.9 Data management**

Data analysis was facilitated using the computer software MaxQDA. This was selected based on its availability and personal recommendations for its use. Using Computer-assisted Analysis of Qualitative Data Software (CAQDAS) is helpful for exploring, coding and comparing large amounts of qualitative data (Payne 2007). The data are easily explored and searched, themes can be coded, checked or reviewed and referring back on the original data is easy. Analysis is assisted by attaching memos to data or codes to record ideas and reflections (Webb 1999).

Concerns have been raised that using CAQDAS may impede engagement with the data (Webb 1999). When first reviewing the data on MaxQDA it became apparent how easy it was to search for terms and quantify the results, for example the term 'epidural' was used 107 times in the first six interviews. The desire to quantify the text data was easily resisted as the advantages of the software to handle the data became apparent. While using MaxQDA, it was easy to refer to the original data which is viewed on the same screen as the coded data. In addition, searching text data for certain terms or phrases facilitates exploring how different participants attach meanings to individual terms or concepts (Seale 2005).

## **6.10 Analysis**

From the interviews I hoped to develop an understanding of hospital birth as it means to labour ward midwives. As I had selected interpretive phenomenology as my approach, both van Manen's (1990) and Fleming *et al's* (2003) frameworks were initially used to guide the analysis. This became a starting point for reflecting on the

meaning of the data. However, the interpretation of the findings was an iterative process and I did not adhere strictly to either framework.

In phenomenological research when data collection begins so too does reflexive analysis (Streubert and Carpenter 2007). This is not a linear process because there is on-going engagement with data within the hermeneutic circle. Field notes taken after the interview were the first stage, and subsequent interviews led to new reflections and considerations of previous interviews. Data merged and separated at various stages of the study as reflection on commonalities and differences enabled themes and concepts to be identified.

Initially, following the interviews and their transcription I spent considerable time with the data. Reading and listening to the recordings I reflected on the freshness of the interviews. I could identify vividly with each interview conducted. The transcribed data were readily imported into MaxQDA and coded to break down into small units of meaning in order to organise and explore the findings.

Data analysis for phase one of the study did not take place in earnest until six months later and over that time I gained more objectivity in relation to what the data were saying. My pre-suppositions were mediated and developed through my confrontation with meanings brought about by reflection and analysis of the data. The coding changed and merged into various themes and interpretations in the quest to seek understanding of the meaning of the experience of the midwives that I had interviewed.

To ensure that I was not misrepresenting individual participants, I listened repeatedly to the original recordings. This was particularly useful and helped me to return to the immediacy of the interview. Analysing the data involved immersion in the data, listening to tapes, making reflective notes, reading transcriptions, considering alternative approaches in order to identify common meanings of the midwives' experience by considering both the text of the interviews and its significance as a whole.

The language the midwives used was important in developing an understanding of their world. The coding initially used to explore the data became less important as the analysis progressed. At various stages reflective notes, diagrams and spider plots

were used to bring thoughts and concepts together. Memos were noted on paper and on MaxQDA depending on which medium was appropriate. All paper jottings were kept together and reviewed and edited as ideas emerged. These were used reflectively to construct further thoughts, as themes emerged and faded and the analysis developed. At times this became an exercise of immersion which brought frustration and occasional enlightenment.

Initial descriptive accounts were written and repeatedly rewritten. This iteration between codes, sections of texts, emerging themes, reflective notes, descriptive accounts and theoretical possibilities formed the basis of understanding the deeper meaning and significance of the midwives' experiences. At many stages it was necessary to return to the original data, both recordings and transcriptions, to ensure that the data were not being misrepresented. In particular, alternative or discrepant possibilities were sought.

A table providing a sample of the coding used in the analysis demonstrating how the A table is contained in Appendix 9 which provides an example of the coding used in the analysis. This demonstrates the iterative process in how the themes emerged.

### **6.11 Trustworthiness of the data**

It is required that interpretive researchers legitimate their research without resorting to positivistic approaches (Angen 2000). This must acknowledge the nature of the methods and analysis used to derive findings. The iterative process based on reflection and reinterpretation does not take place in a linear fashion that is easily transparent or reproducible. The trustworthiness of the findings of this study comes from the honesty whereby they are produced and whether they resonate with both the individuals who contributed to the study and to others in a wider field.

Using an interpretive approach assumes that reality is construed intra-subjectively and inter-subjectively through the meanings and understandings acquired from a social world (Angen 2000). With hermeneutic phenomenology there is no understanding without interpretation and this understanding cannot be separated from its context. The midwives I interviewed shared with me their experiences of working within two diverse labour ward environments, one old and one new. My supervisors had all the transcripts, and assisted with the organisation, description and



interpretation of findings. These were debated at various stages as the analysis became refined and findings reflected on and rewritten.

The findings from the study have been presented to the midwives in Hospital D. It was reassuring that they were not surprised with my analysis and interpretation of the data. I was told repeatedly that *'that is how it is'*. When I sought further confirmation, I was informed that they saw my presentation as their experience being reflected back to them. Credibility and confirmability are the important components of trustworthiness (Holloway and Wheeler 2002). I was reassured when I obtained this from the midwives who attended the presentation.

### **Conclusion**

This chapter has provided the details of the methods used to undertake this study. The focus in this chapter was on the methods used for Phase I, the interviews with the labour ward midwives in the hospital which was due to close. During these interviews the midwives were asked about their experiences of working in the unit and what being a midwife meant to them in this context. Through the analysis of the data I hoped to reveal the meaning and sense making that the midwives had for midwifery practice in this long established maternity unit. The next chapter contains the findings from this phase of the study. As will be apparent, the findings from the first phase resonate with Lipsky's work on Street Level Bureaucracy and the findings of the metasynthesis. Foucault's work on the nature of power and surveillance was also evident. This will be discussed later in Chapter 14.

## CHAPTER 7 'CALM BEFORE THE STORM'

### **Introduction**

The reason for the title of this chapter will be apparent as this thesis progresses. Presented here are the findings of the first phase of this study. The data are from interviews with six labour ward midwives who worked in a stand-alone maternity hospital (Hospital A). This unit closed less than twelve months after these interviews were undertaken.

Of the six midwives selected for interview, Jennifer, Margaret and Sandy had both trained and worked in other maternity units, Jennifer in Scotland and Margaret and Sandy in England. The other three midwives worked as midwives only in their current setting. Two of the midwives, Amelia and Sandy were considered to be 'junior' midwives with three and four years labour ward experience respectively. Sarah, Marie, Jennifer and Margaret had between 12 to 18 years of labour ward experience; most of this within this particular labour ward (see Appendix 7).

In this unit, as in other Irish maternity hospitals, unless there was a need for medical involvement or the women had booked private obstetric care, the midwives provided all care throughout labour and birth. Doctors were consulted as required. For women who booked private care, the consultant obstetrician was informed when the woman was in established labour so that they could attend for the birth.

The experiences of the midwives are described in this chapter. This chapter is titled the Calm before the Storm as the storm metaphor is relevant to the later presentation of findings where the activity levels in the new hospital is represented by a storm of activity. The themes that emerged from the analysis of the data were 'consensus of care/compliance with norms', 'powerless to change', 'new life and nice work', 'immanently contested space', 'changing practice and learning new skills', and finally 'uncertainty ahead' which reflected the planned transfer of services to the new hospital several months later. Quotations from the interviews are used throughout the findings sections. The names of the midwives have all been changed and the reference numbers beside their names refers to the original transcripts of the interview and the page and line numbers of the relevant section of text.

## 7.1 Consensus of care and compliance with norms

The midwives described a busy unit where they had little autonomy over the care they provided. The unit was consultant led, and with approximately 40% of the women attending an obstetrician privately. According to the midwives, these women looked to their consultant to make all decisions about the management of their labour and the midwife was expected to comply. Anaesthetists could wander into the labour room to offer an epidural. When a midwife was on a break, the midwife who relieved her could intervene in care without any discussion with the primary midwife.

The midwives informed me that there was a high level of intervention in labour and they blamed this on the busyness of the unit and the medicalised approach to childbirth. While they had responsibility for the care of individual women, usually providing one to one care, they took no responsibility for the interventionist practices that were the norm. The protocol for 'Active Management of Labour' (O'Driscoll et al. 2003) was not the policy of the unit at this time but midwives referred to labour as being actively managed:

*to be honest with you it very much an 'active management' unit here and like people come in and say 'does she need to have an ARM?'*

*Amelia (5, 5-7)*

During the day shift, the midwives frequently cared for women having their labour induced. Sarah described the interventions that can happen:

*(the women) are so many days overdue, they get Prostin<sup>11</sup>, they get their 'waters broken' (ARM), they get put up on Syntocinon<sup>12</sup> and so on. You know, and if they are on Syntocinon they are continuously monitored<sup>13</sup>. And there is a big push, push, push for that and if they don't come on (progress),*

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<sup>11</sup> Prostin is a pessary inserted vaginally to prepare the cervix for amniotomy. It is undertaken as part of induction of labour

<sup>12</sup> Syntocinon (oxytocin) is a drug which stimulates uterine contractions. It is administered intravenously to induce or augment labour

<sup>13</sup> When the midwives speak of 'monitoring', this refers to continuous electronic fetal heart monitoring, also referred to as a cardiotocograph or CTG. This involves a probe being attached to the woman's abdomen to provide a recording of the fetal heart rate. Alternatively an internal probe is attached vaginally to the fetal scalp. The presence and duration of uterine contractions is also recorded which requires that she remains in bed

*it is a failed induction . . . if they (the doctors) think the baby is going to be big and they may section (caesarean section C/S) them . . . maybe the women just ask for it (C/S) . . .* Sarah (3, 6-15)

This stereotypical description of a cascade of intervention has been described elsewhere (Roberts et al. 2000, Tracy and Tracy 2003). The midwives in this unit associated intervention in labour with instrumental or operative births. In the quote above, Sarah did not accept responsibility for this type of labour as the induction was ordered by a doctor with the woman's consent.

The number of women being admitted to the labour ward for induction of labour contributed to the workload and impacted on the quality of care midwives could provide:

*it is so busy and you are under pressure for beds and it is as if you are just herding somebody out, as quickly as you can . . .* Marie (3, 28- 30)

When a birth was complete there was pressure on the midwives to transfer the woman out of the labour room as there would be another woman waiting for the bed.

In their dialogue, the midwives were generally loyal to their work colleagues but they were aware of differences in practice; some midwives were recognised as being interventionist in labour such as routinely performing ARMs, accelerating labour and even performing episiotomies<sup>14</sup>, while others promoted normal childbirth:

*you get to know your colleagues and you get to know how they work so I mean different midwives do different things and some people do a lot of episiotomies and so on and some people don't you know* Sandy (9, 3-6)

Because the midwives worked closely together, often sharing a labour room, they were aware of each other's practice. Sandy was one midwife who was quite critical of the practices in the unit:

*The school of thought seems to be that they (the women) sit in the bed and get strapped up to the monitors . . .* Sandy (1, 25-26)

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<sup>14</sup> An incision made in the pelvic floor to enlarge the vaginal opening prior to a birth

According to Sandy, these practices were not of concern and were accepted by both midwives and doctors. The expectation was that the women would be cared for in bed, attached to a fetal heart monitor and receive an epidural for pain relief as requested. Apart from the woman's right to receive an epidural, all other decisions were made by doctors or midwives.

Some midwives encouraged mobilisation where they could, but the lack of space, shared rooms and the busyness of the unit, limited their opportunities for this. Where normal birth happened, it occurred almost by chance and few midwives used strategies to support this. Apart from some like-minded midwives, normal childbirth was generally not discussed by the midwifery or medical staff and did not appear to be valued. Most midwives complied with the norms of practice and new midwives were required to adapt. As Jennifer, a senior midwife stated:

*I go along with it really. . .*

*Jennifer (5, 4)*

The midwives' dialogue resonated with the studies reviewed and analysed in Chapter 4. Every conversation highlighted the normalcy of intervention, with frequent mention of inductions of labour, epidural analgesia and caesarean sections. This was the reality of the midwife's world where little changed and with a few exceptions the midwives were compliant with the system of care.

Sarah spoke about a midwife who came from a very different practice milieu outside Ireland. She notes that this midwife had to work differently in the hospital. The midwife retained her skills for normal birth but compromised her practice to work in the unit. Sarah recognised the skills that this midwife had in supporting normal birth:

*Midwife X used to do home deliveries, she used to do them even for new age travellers and everything, in camp sites, (now, on the labour ward) she just has to accept it more or less, because that's the system and that's what is expected, she works in Ireland and that's it, that's what happens here. Probably she just fits in and monitors or whatever . . . If any woman wanted a normal labour and delivery she would do it, but she just fits in . . .*

*Sarah (4, 15-23)*

While I had hoped to interview this particular midwife, the opportunity did not arise and she has subsequently left the maternity services.

Despite the high levels of intervention, there were some midwifery practices that had changed over recent years:

*I think it has definitely changed in the years since I have been there (12 years) it was very much interventionist when I first came. When (the women) came up, first they were examined vaginally more or less straight away as well, and did an ARM as well, whereas that has got a way more lax.*

*Margaret (1, 28-31)*

Margaret had achieved a degree of autonomy in her practice whereas other midwives informed me that a vaginal examination and ARM on admission was still the norm. Margaret did not always comply with a medical order if she considered it inappropriate:

*even with that coming up (to the labour ward) if I am assessing them and I think she is not suitable for an ARM, I don't do it, and I suppose if the doctors come around I say 'she does not have much pain and I have got her walking around for a while*

*Margaret (1, 43-45)*

While space within the labour room was limited the women could walk on the labour ward corridor if there was not too much activity there. Margaret was one of a few midwives who did not see the lack of space as a barrier to encouraging mobility or alternative positions for labour:

*definitely if you can get them out and about, or even get them up on their knees on the bed if you don't have the space or if they have the monitor*

*Margaret (3, 35-36)*

For the midwives that had only experienced midwifery in Hospital A, they all accepted the practices of the unit without question. Midwives, who had worked elsewhere, adopted their practice to the norms for the unit. For these three, Jennifer had long accepted the consensus of care, Margaret appeared to have negotiated a space for herself so that she could still practise the type of midwifery she enjoyed,

and Sandy seemed to be in conflict both with the system and other midwives who were resistant to change.

## **7.2 Powerless to initiate change**

All the midwives I interviewed accepted the way labour was managed in the hospital, or felt powerless to do much about it. There were various comments that reflected their position on this:

*It is something that we grow up with, we go along with really, but it's the way it's done, so you don't have a choice really* Marie (4, 5-6)

Midwives felt they had little autonomy in their work, particularly on day duty. They claimed that doctors could enter a room and provide direction to the woman without regard for the care being provided by the midwife:

*(Doctor) would say 'you are not pushing too well' . . . I suppose if it was (a midwife) who is not as experienced you might take offence . . . he came in at the wrong time I suppose . . .* Margaret (3, 22-26).

Anaesthetists could also wander in to offer a woman an epidural:

*. . . he might come in and say to a woman . . . 'would you like an epidural, just in case' . . . 'I want to tell you about it now before it (pain) is too bad . . . you might be screaming later and you would not understand what I am saying to you'* Sarah (3, 32-39)

Other midwives could also interfere such as performing an amniotomy while the midwife had a break. This was expressed by Sarah, a midwife with 18 years' labour ward experience:

*You might find that you are gone to your tea break and you come back and it (ARM) could be done because (the midwife) might say, 'I will break your waters' . . . and it would be done and you think 'I would not have done that and it is I who was minding her' . . .* Sarah (8, 15-20)

Interference by doctors or other midwives was mentioned by all the midwives. They complained about it but did not often speak out when it occurred. It was one of many things that they felt powerless to change.

When discussing private obstetric practice the midwives had even less autonomy as these women looked to their consultant to make decisions around care:

*if there are private patients the first thing they (consultant) ask you to do, is to 'get her an epidural' and she is only up there 5 minutes, (and the woman may be) mobile and doing her own thing . . . some people (midwives) feel pressurised by that and to get it straight away . . .* Margaret (4, 16- 27)

The midwives reported that they often experienced pressure from doctors for women to progress quickly in labour:

*they (doctors) may want to augment them or whatever at their discretion, even if she (the woman) is doing ok, or it might be that the woman is maybe 5 cms<sup>15</sup> and they haven't had an ARM and they want an ARM done . . .* Sandy (10, 40-43)

Midwives did not challenge consultant obstetricians but might negotiate with registrars who cared for public women. Sandy found it easier to discuss options with doctors but spoke about the potential for conflict with other midwives:

*I find it nearly easier sometimes to deal with the medical teams as a professional rather than deal with one's own colleagues who have maybe been in the place longer than me.* Sandy (2, 22-24)

It was senior midwives who determined practices, and when Sandy challenged what she perceived to be the unnecessary use of interventions, she anticipated a negative response:

*Maybe that kind of 'who do you think we are' kind of attitude 'who do you think you are this is the way we have being doing things for years', 'it has*

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<sup>15</sup> Progress in the first stage of labour is assessed by vaginal examination to ascertain cervical dilatation. This is measured in centimetres (cms). Ten cms equates with 'full dilatation' and indicates that the woman is in the second stage of her labour.



*always, it has been working for us' and maybe that is the way they were taught.*

*Sandy (2, 32 – 34)*

Sandy spoke about trying to initiate change while at the same time maintaining good relationships with her midwifery colleagues. Midwives were aware that differences might be tolerated depending on which midwifery manager was on duty at the time:

*you know, it very much depends on who is in charge or whatever*

*Sarah (2, 41-42).*

As with the previous theme, consensus with care, because of the accepted ways of practice in this unit, midwives complied. Even where they perceived that there might be alternatives which might be in the best interest of the woman, there was little opportunity to question practice or bring about change. This powerlessness among the midwives was said to be due to the high levels of private obstetric care; and the accepted practice for any midwife or doctor to become involved in the care of any woman. If the midwives wanted to continue to work in the unit they were required to accept these norms.

### **7.3 New life and nice work**

Despite these difficulties, the midwives all enjoyed labour ward work and in particular they shared with the women and their partners the joy and excitement of a birth:

*I suppose there is a bit of excitement in it; the babies been born, always something new, something happening.*

*Sarah (1, 15-16)*

Others reflected this as the positive aspect of their role:

*there is great job satisfaction out of it at the end of it . . . the women and babies and you know, new life and nice work, happy most of the time, it's lovely, new life, it's great*

*Jennifer (6, 32-35)*

All the midwives preferred to assist women who were in spontaneous labour and if she also had a normal birth this added to the affirmative aspects of their work. This provided both the woman and her midwife with a positive birth experience.

*There is no doubt that the woman who comes up in labour naturally and progresses and has a normal delivery without any interference, it is much nicer*

*Sarah (1, 26-28)*

While a normal birth was the best outcome, where a woman had a caesarean section or instrumental birth, the midwife still obtained satisfaction by assisting women through what could be a negative experience. This was explained by Margaret:

*whatever way people labour or deliver I like them to have a good experience and for people (women) to be confident about it or even if they are having a (caesarean) section or a vacuum or a forceps I suppose you kind of are helping them along is the reward you get and how they feel afterwards and seeing them with their babies it is always a miracle.*

*Margaret (9, 33-37)*

Positive birth experiences with minimal intervention was more likely to happen at night time when there was less interference by senior midwives or doctors and the unit was quieter. This was preferred by many of the midwives, the atmosphere was more relaxed and the midwives had more freedom in how they could provide care. This was described by Jennifer:

*on night duty . . . we kind of let them (the women) 'do their own thing' . . . it isn't as busy and you have more space and you don't have the inductions . . . and once I am happy with that (CTG)<sup>16</sup> tracing and everything is fine and she can walk around, she can do whatever she likes to and there is no hassle . . . it doesn't really happen (by day) . . . it is busier and there is not much room for them to move around and you don't have the kind of autonomy on day duty . . . (on night duty) they will come into labour itself and it just happens, it happens easier*

*Jennifer (2, 6-32)*

In contrast to Sarah's previous description of an induced labour which resulted in an instrumental birth, Sandy describes a birth experience which commences spontaneously. If Sandy assisted a woman in spontaneous labour to have a natural birth it was a good day (or night) for her:

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<sup>16</sup> CTG refers to a cardiotocograph which monitors the fetal heart rate and uterine contractions.

*the woman comes in, she is confident in the ability of her own body, and immediately you are meeting somebody who you can work with and support that they aren't already closed in . . . so they are open so you can discuss it . . . and give them the best advice you can . . . and it is very straightforward and normal and the woman delivers whichever way she wants maybe she is kneeling or she is on all fours . . . and when the baby is born the woman gets a little bit of time with her baby and it is nice and peaceful without interruption, and that's just a, that's a fulfilling day for me*

*Sandy (2, 40 -45; 3, 1-6)*

These ideal type births were experienced by midwives from time to time. In this situation, the woman has had a positive experience and is grateful to the midwife for the care provided. For the midwife, it provided a sense of satisfaction of a job well done. As Margaret also highlighted, even where a woman had a difficult birth, it is the midwives' role to try to make this an optimal experience. Midwives shared with parents in the joy of the birth.

#### **7.4 Immanently contested space**

As discussed in Chapter 2, the debate around the nature of childbirth has been contested between biomedical and more sociological approaches (Murphy Lawless 1998, Hyde and Roche-Reid 2004, Davis and Walker 2010a). The labour ward as a contested space was evident from the metasynthesis in Chapter 4 and also in the dialogue of these midwives. There was a desire among midwives towards the normalisation of birth yet they worked in an environment where normal birth most often occurred by chance. A scenario that demonstrates this was articulated by Amelia:

*one woman who stands out in my mind . . . the membranes just started bulging outside the perineum and it was fabulous, the caul was born over the baby's head . . .the waters bulged, somebody (a midwife) was coming with an amnihook<sup>17</sup> . . .*

*Amelia (5, 1-5)*

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<sup>17</sup> Just before the birth, the fetal membranes are intact and appeared at the vaginal introitus. The membranes rupturing as the baby emerged. The caul refers to the amniotic membrane covering the

From Amelia's account it seemed that the midwives were surprised. This birth was rapid and if time had permitted an amniotomy would have been performed. This was a chance event that the midwives present had not witnessed before. The assumption was that a woman could not give birth with her membranes intact.

Scenarios like this led me to consider the environment that the midwives worked in as an immanently contested space. Whenever a midwife was providing care, within this space, at any time another midwife or a doctor could potentially become involved. Where the primary midwife was in the process of supporting a woman, avoiding intervention, perhaps seeking to 'normalise' a birth, the midwife or doctor who entered, could suggest an epidural or change the midwife's plan of care. This could be without the need for any discussion. While this did not happen in every situation, the potential for it to occur was always present. Thus the potential for alternative trajectories for labour and birth was always possible and sometimes emergent. Midwives described positive births as being due to 'luck'.

This was apparent in a number of birth stories recounted. Just two are included here as situations whereby the midwives aspired to the ideals of 'real midwifery' (as defined on p. 37) and the challenges they faced in providing this. In the first story the potential for conflict was present, but did not emerge as Sandy did not raise her disquiet. In the second account, related by Margaret, all went well and the woman experienced the type of birth that she wished. Margaret described this 'as luck'. If a different midwife had been present, or had intervened, the outcome may have differed.

The first story is provided by Sandy who is caring for a woman who was progressing well and coping with her labour. Another midwife relieved Sandy:

*... a primigravida<sup>18</sup>, mobilising and everything was ok ... and when I come back (from my break) the woman is in the bed and with an epidural and the*

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baby's head. A rare sight for labour ward midwives. An attempt was made to rupture the membranes with an amnihook.

<sup>18</sup> Primigravida refers to a woman who is experiencing her first pregnancy

*drip (I/V) and the catheter and her waters are broken<sup>19</sup> . . . it is just very soul destroying because at that particular time the woman was coping great, but then once she is lying down with the epidural she suddenly feels better so it makes you look really bad, as if you weren't supporting her but at the time everything was grand and but it is just two different scenarios and a different woman and you go back and 'oh this feels great now, I was really tired I can lie down here now', and her trust (in you) is gone. . . it isn't that you were blocking her from having it (epidural), she was coping fine and it's just that the alternative happens and it makes you look bad. Sandy (3, 34-45)*

In this incident, the confusion for Sandy was in not knowing what the right course was. It is not clear what emotions Sandy felt, sadness or disappointment, for herself or for the woman in labour. Sandy perceived that she was facilitating this woman towards a non-interventionist birth, or at least delaying the need for intervention as the woman was coping well. That another midwife altered the care and the woman was pleased with the change is confusing and highlights a dissonance (Festinger 1957) for Sandy in trying to understand what was best for this woman. This incident led to uncertainty and self-doubt. This will be discussed later.

In contrast, in the story below, Margaret appears to have reconciled her dissonance, being comfortable providing care for women receiving a medicalised approach to birth while at the same time facilitating another woman to achieve the natural birth that she wanted.

Margaret's narrative illustrates how on a busy day in a cramped environment, the decisions she made facilitated the woman to have the type of birth she wished to have. On this occasion, just by chance, the space was not directly contested:

*We had a busy day there and one girl came up in labour, I had two (women) in one room, one girl was kind of doing her own thing and actually really it was her, it was very busy and I'd say if she had said 'I want an epidural' I would have said 'yeah fine' but she actually was great herself. I think a lot of it comes from the women themselves and if they want to mobilise or and*

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<sup>19</sup> A woman who receives an epidural for pain relief will require an I/V infusion to maintain her blood pressure and a urinary catheter because of reduced bladder sensation and the potential for over distension

*she said afterwards . . . that we 'were so calm' that we 'did not mind what she would do or didn't do', and she was getting very distressed, but she still wanted as natural a birth as possible. She was I suppose about 4 cms when she came up and then later she was still 4 and maybe she wasn't 4 earlier on, and your inclination would be to break the waters maybe then, but I suppose she was kind of disappointed that she was not further on, but I said 'give it a bit of time, there's no panic' there was 'no major rush' and then the other woman I had was labouring, she had an epidural, and she (the woman who wanted a natural birth) really persevered and carried on, and next time she was examined she was actually 8 cms, and she was delighted and she was up and out and moving around, and she delivered a 10 lb. baby squatting . . . the student . . . was doing a lot of her care . . . I was delighted for her to see that, I suppose you had combined the two things in one room really, and you can do it.*

*Margaret (2, 44-46; 3, 1-19)*

In this scenario, Margaret was caring for two women in a shared room with the assistance of a student midwife. Despite the lack of space, she facilitated the woman to give birth in a squatting position without much fuss. The reassurance and support Margaret provided facilitated this outcome. Margaret knew that she had made a difference to this woman's experience and spoke about the joy this woman felt:

*That girl actually sent a card, the lady who was squatting, and she was so thrilled herself to have a (normal birth) she didn't think that she would do it herself. A lot of it is getting them (the women) to believe they can do it themselves, but she was so delighted with the way it went so as well we were delighted too (laughter) and sometimes it is luck I think that it works out*

*Margaret (9, 44-46; 10, 1-3)*

While at the time Margaret gave the woman confidence in her ability to have a natural birth, she still considered that it as luck that the birth had turned out so positively. Margaret spoke about her need to have experiences like the one described:

*(I) have to do that or otherwise and I shouldn't be there . . . I suppose I have to get some way of working myself or I might as well leave . . .*

*Margaret (6, 16-17)*

She went on to speak about the frequency of the doctors entering a labour room and the expectations that frequent vaginal examinations would be performed. While she did not challenge doctors or other midwives, when opportunities arose, she tried to normalise birth. In providing this story, Margaret felt that this woman was lucky to experience this type of birth on a busy day. If others had become involved, the woman's experience might have been different.

Both stories and the other accounts provided by the midwives illustrate the labour ward as an immanently contested space. The midwives blame the intervention in childbirth on doctors but there is also evidence of interference and the struggle midwives have within their own professional group. While doctors may send women to the labour ward for induction or to receive an epidural, it is other midwives who are more likely to intervene in a midwife's care.

Midwives who maintain that birth is a normal life event but practice as if intervention in labour is the norm may experience cognitive dissonance. These inconsistencies are uncomfortable to hold, and, as a consequence, individuals attempt to rationalise the inconsistencies for themselves (Festinger 1957). The midwives I interviewed did not accept responsibility for the levels of intervention in the unit and blamed others for this. Where dissonance occurs, midwives are likely to either seek to normalise birth or accept medical input because by doing this they move towards consonance. This enables them to resolve the inconsistencies which are otherwise uncomfortable to hold. Sandy struggled with the level of intervention in the unit whereas Margaret had reconciled the inconsistencies where, if she could occasionally experience have a positive birth, could move between both types of birth without difficulty. Both midwives were interviewed again for Phase II. In the new hospital, Margaret divides her time between the labour ward and the obstetric theatres, whereas Sandy has since left the labour ward.

## 7.5 Changing practice and learning new skills

In order to gain a greater understanding of the midwives experience I probed to find out how the midwives had developed their own approach to practice. Three of the midwives interviewed had trained in the UK; the other three had not worked elsewhere.

From Amelia, it appeared that junior midwives focused on developing practical skills so that they were not reliant on other midwives coming to their assistance:

*I suppose it took a good 1½ to 2 years to feel a bit more comfortable, to feel more confident and with women in labour and because it is such a responsible job and a skill I still have to work on . . .* Amelia (1, 14-17)

Though qualified for four years, Amelia was learning the technical skills required to work proficiently in the unit. She was now confident in suturing<sup>20</sup> and performing ARMs, but she was also learning strategies to support women through labour. The latter did not seem to be seen as equal value to technical processes, despite being central to the core midwifery role of support in normal childbirth.

For more experienced midwives, the discussion focused on how practices had changed or evolved. All spoke about learning from observing their colleagues:

*You are always learning something new from other midwives, and you think to yourself I will be more aware of that the next time* Sarah (8, 9-11)

As two midwives were present at each birth, they had the opportunity to witness a variety of approaches. From this a midwife could select strategies that she perceived were most beneficial for the woman. Midwives who had similar approaches, had opportunities to discuss practice and the difficulties they were experiencing but though they wished to change practice they felt powerless to do anything about it. Sandy considered that holding staff meetings where practice issues could be discussed would help:

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<sup>20</sup> Following an episiotomy or perineal tear, the perineum is sutured by a midwife or doctor as necessary



*. . . say going to discuss ARMs and then we would all just say 'why are we doing them' or 'are we doing too many of them' and the same way with positions (for birth) or we could say ok 'now that we are not going to do so much continuous CTGs can we get people to use alternative positions' . . . It does not happen but many of us have said that it would be great if it did happen*

*Sandy (8, 27- 38)*

As discussed previously Sandy found it hard that midwives were working from different approaches to care.

Apart from learning from observing others, when I asked Marie about assisting women to give birth in different positions she indicated that this had come from the women. She trusted that women in spontaneous labour would instinctively know what position was needed for labour and birth:

*It came from what they ask 'can you do it', I probably seen it once or twice . . . but it came more from the women . . . telling me what they wanted, if you are with somebody for a while, you know how they feel comfortable and if they wanted to squat, you understand that the pelvis is going to widen out when they are squatting or standing and mostly if you watch them, they would be kind of rocking from side to side or kind of half standing . . . but mostly if you watch them and if she is in tune with herself . . .*

*Marie (5, 10-17)*

It may be that, in this unit, some midwives were more sensitive to the needs of individual women, and could interpret the signs that labour is progressing without the need for dialogue. Marie had confidence that the woman can give birth by following her own intuition, but recognised that the woman must also have this belief. For midwives and women, who first encounter each other when the woman is in labour, it may take time for each to sufficiently relax and trust in each other for this harmony to occur.

## **7.6 Uncertainty ahead**

The final theme that emerged was about the uncertainty that they felt about the move to the new hospital. The midwives were aware of the date of the proposed opening

less, than twelve months later, yet they were unsure of how this would be and seemed somewhat uninvolved. Though there had been opportunities for them to visit the hospital, they were vague about the move even being unsure as to where they would be working. There were divergent concerns that the larger unit would be even more medicalised; though some midwives hoped that there would be opportunities for midwifery-led care.

Amelia expressed some concerns about the proposed new service

*I hope that it won't become conveyor belt medicine* Amelia (6, 3)

As will be seen in Chapters 12 and 13, Margaret was more prescient about what might happen in the future:

*I suppose it depends, if you can get the policies and procedures up to some kind of you know proper standing that would be good . . . the privacy will be good . . . you can do your own thing to a certain extent which will be good and psychologically for the women as well* Margaret (8, 6-12)

Jennifer also hoped that there would be positive outcomes from the move:

*Maybe it will change; I hope that it would be a more midwifery led* Jennifer (5, 24)

Two other midwives were quite pessimistic in how they anticipated it would be. As Sarah said:

*If it is possible . . . it will go more and more (medicalised), it is going to be Prostin, ARM, Syntocinon, 'push', there is only ten labour ward beds there, in the new unit, we have six here and if we have just ten with all the deliveries how are they going to manage it, you can -it is going to be push, push, push to get them all out* Sarah (4, 5-12)

Sandy shared these negative views about the system of care:

*. . . I think that with that many extra thousands of people coming in that there is going to be much more timing of births and there is going to be much more inductions and I think that while it could be great as we will all have single*

*rooms and more modern facilities . . . but I can see that there will be lots of medical rounds and lots of Syntocinon and so on* Sandy (7, 8-14)

How the midwives fared during the move will be explored in Chapter 10 and their experience of working in the new larger hospital will be subsequently explored in Chapters 11-14.

## **Conclusion**

The data presented in this chapter reflects the experiences of the labour ward midwives interviewed in a hospital which was due to close. The themes that emerged from analysis on the data were ‘consensus of care/compliance with norms’, ‘powerless to change’, ‘new life and nice work’, ‘immanently contested space’, ‘changing practice and learning new skills’, and finally ‘uncertainty ahead’.

The midwives described an environment where a technocratic approach to birth was evident. Intervention, such as induction of labour, use of amniotomy and continuous fetal heart monitoring was the norm rather than an exception. Midwives accepted this approach as they enjoyed labour ward work. They complied with the norms for the unit and claimed to be powerless to bring about change. As has been previously reported (O’Connell and Downe 2009), there were midwives who sought to normalise birth but encountered difficulties as the space for labour was immanently contested. Surveillance was an expectation and midwives or doctors could enter a room and potentially intervene in the midwife’s care. Midwives worked closely together in the shared rooms and were aware of each other’s activities. In this labour ward, Amelia stated that it took her two years to become a confident midwife. Technocratic skills were valued but Amelia also admitted to developing skills to normalise birth. While the unit was due to close, the midwives were vague when discussing their imminent move to the new, much larger hospital.

As the midwives spoke about their experience, their dialogue reflected other studies in this area which were reviewed and presented in Chapter 4. The experience of these midwives was similar to midwives in other units, whereby the reality of labour ward midwifery practice falls into three arcs of activity, ‘getting through the work’ and providing an equitable service for all women, enforcing compliance to technocratic norms in order to ‘get through the work’, and discursive, subversive,

and occasional resistance, in an attempt to provide ‘real midwifery’ for individual women (O’Connell and Downe 2009 p. 602).

The midwives in this hospital did not report subversive activity, but they were all discursive about the technocratic approach to birth in the unit and dissonance was evident in many of their accounts. Junior doctors could be challenged but compliance was expected from consultants and senior midwives. ‘Real midwifery’, whereby the midwife facilitates the woman to positively experience an intervention free birth, was a rare event and occurred almost by luck. As will become more relevant in the next stage of this study, the language the midwives used indicated that women were largely passive throughout the midwives’ account of their care.

The next chapter is an account of how the next stage of this study was undertaken. In the chapters following this, what happened to the midwives when they moved to a new and much larger hospital will be explored.

## SECTION 3 SECOND STAGE OF DATA COLLECTION

### CHAPTER 8 METHODS

#### **Introduction**

The next stage of this study was to interview labour ward midwives in their new setting. This chapter introduces this second phase and main body of the study. It provides an account of the opening of the new hospital and how I planned and undertook the next set of interviews. The ethical issues, method of analysis and trustworthiness of the data are not repeated here as these details were provided in Chapter 6, and no new issues emerged.

The new maternity hospital had been constructed as a 'centre of excellence' to manage an estimated 7,500 births per year but in 2008, the first full year of activity, there were 8,788 babies born (mean = 24.1 per 24 hour period) (unpublished Hospital Report 2008). Moving to such a large hospital required considerable adjustment for all staff. I was interested to see how this would impact on the labour ward midwives' perceptions and understandings of their midwifery practice, and how they would now interact with women in a changed environment. I also wished to explore how the midwives from a variety of units would come together to form a new entity, if they would learn from each other, and whether the new setting would lead to changes in practice. A decision was made to wait at least twelve months after the move in the hope that some of the anticipated difficulties in the opening would have abated.

#### **8.1 Access to setting**

Ethical approval for this, the second phase of the study was sought from the CREC in December 2007 and the FHEC in April 2008. Approval was obtained from both bodies without difficulty (Appendix 3). Following this I contacted the Director of Midwifery for permission to access the midwives in the Labour Ward; again approval was provided without delay. The relevant Clinical Midwife Managers were then approached to discuss the study. With their agreement, I commenced visiting the new labour ward to meet with and recruit midwives for this phase of the study.

Access to the unit was relatively easy and most of the midwives, even those I did not know, were friendly, and willing to hear about my study. As before, some were clearly less interested and during subsequent visits appeared to avoid me; I therefore considered that these midwives did not wish to be involved. My visits to the unit took place at various times of the day and night and included weekends.

## **8.2 Labour ward setting**

The labour ward is on a curved corridor with the Midwives Station half way along. There is a five bed Induction Room, ten individual Labour Rooms, a Home from Home Room, Birthing Pool Room and a five bed High Dependency Unit. The Birthing Pool was not being used at the time as its use had not been sanctioned by the hospital management team. Maternity and gynaecological theatres are situated adjacent to the Labour Ward (See Appendix 2).

The individual labour rooms are small and contain an Ave ® Birthing Bed<sup>21</sup> in the centre with a neonatal resuscitaire alongside. Oxygen and nitrous oxide (Entonox)<sup>22</sup> are piped and can also be administered in the attached bathroom. Other equipment includes an electronic fetal heart monitor, I/V stand, trolley and various supplies and equipment to administer epidurals, induce labour, conduct normal and instrumental births. The partially shaded window looks on to a busy junction and the noise of traffic is audible if the window is open. A selection of music can be played in the room or the woman can bring in music of her choice. Birthing balls, where available, are stored in the bathroom.

The door into the labour room had a glass panel and a curtain placed just inside the door was drawn when the room was occupied. A red light outside signified that the room was 'In Use'. During visits I observed some midwives and doctors knocking before entering, while others entered directly.

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<sup>21</sup> The new beds were adjustable and could be used for various positions for labour and birth. In particular, they can be used for sitting (chair position) and also or all-fours positions as well as the more conventional semi-recumbent or lateral positions. Stirrups are attached if the lithotomy position is required.

<sup>22</sup> Entonox (50% nitrous oxide, 50% oxygen) is an inhaled gas with analgesic properties which is self-administered

### 8.3 The organisation of midwifery work

For each day shift, twelve to fourteen midwives were rostered and three of these were assigned to theatre. For the night shift twelve midwives were rostered but again three were required for theatre if obstetric procedures were being undertaken. The number of student midwives varied but could be four or five per day shift, with two or three on nights. The majority of midwives worked 36 hours per week as three twelve hour shifts, which could be on days or nights.

In Hospital A, the midwives had described their unit as *busy*. In the new hospital, busyness was rarely mentioned. The labour rooms were almost always full and there were usually women waiting for space. This workload was now the accepted reality for the midwives.

The heavy workload of the labour ward staff was apparent during each of my visits. The Midwives' Station was a central meeting place for all staff and could be described as the hub of the very busy working environment. It had a White Board<sup>23</sup> which contained a list of names and relevant details of the women in the unit; this was usually full and the 'In Use' light was visible outside individual labour rooms. The midwifery manager and other midwives were frequently on the phone to find 'beds' in the postnatal ward or dealing with requests to accept women either in labour or for induction. The obstetric theatres and high dependency unit generated considerable activity. The Midwives Station was a hub of activity particularly during the day with doctors and midwives approaching the desk for a variety of reasons.

At the time, there were only ten labour rooms, but up to twelve women could be booked in daily for induction. The midwife managers would review the list and women could be phoned and advised on the possibility of delay. At times the woman's admission for induction would be postponed. Over the latter months of data collection, the pressure of women waiting for induction reduced due to the opening of the Induction Room. The staff numbers did not increase to facilitate this; the agreement being made was that one of the labour rooms would be 'closed'. At times this closure was honoured but pressure on space frequently required the

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<sup>23</sup> A wipe clear White Board records the status of each woman in the unit and is updated by the midwives to track progress in labour. The name of the attending midwife is included. Names and contact details or doctors on call are also provided.

midwives to use this room in addition to the 'Home from Home' Room which had essentially become an 11<sup>th</sup> labour room. This particular room was generally disliked by the midwives as it was small and cramped and also contained all the standard labour room equipment.

The duration of my visits to the unit varied from a few minutes to, more usually, 20 - 40 minutes, waiting to catch midwives as they emerged from various rooms. Despite the obvious busyness and level of activity, the differences between this and Hospital A was apparent. The line of ten labour rooms 'In Use' made me question how the activity on the labour ward corridor and Midwives Station impacted on what was happening in the individual rooms. One to one care was provided as the standard of care and each woman had a midwife allocated to her. I wondered whether the midwives I had previously interviewed had more autonomy here.

#### **8.4 Sample Phase II**

Purposive sampling was partially used to identify participants for Phase II. Over 80 midwives worked in the labour ward at the time. The majority had transferred from two of the three amalgamating units but additional midwives were recruited to meet staffing requirements. As I was interested in how the midwives had adapted to the unit I hoped to interview staff from each of the three previous hospitals (Hospitals A, B and C), and also those who had been recruited following the opening. I hoped to obtain a range of perspectives and anticipated that 15 to 20 midwives would be required. I visited the unit during different shifts and talked to any midwife who could give me a few minutes of her time. If a midwife showed interest in the study I gave her the information sheet (Appendix 10). While there were many midwives that I did not know, the acceptance of others on the unit paved the way for me to chat to all the midwives I met. Potential participants were asked to read the information sheet and to contact me if willing to be interviewed. Five midwives contacted me by phone or sought me out at a further visit. Others agreed to be interviewed when I next met them on the unit. I consulted the weekly off duty so that I could return when I knew that midwives who had declared an interest would be working. Recruitment and data collection continued over a six month period. In total I interviewed 17 midwives for this phase of the study. All were self-selecting (Appendix 7). Seven of the midwives had transferred from Hospital A, six were



from Hospital B, one had been a student midwife during the transfer, one had returned from leave and the other two midwives had commenced working there following the opening of the hospital. Four of the six midwives interviewed in Phase I agreed to be interviewed again. Unfortunately I did not interview any midwives from the third amalgamating maternity unit, Hospital C (a private hospital), as none were working in the labour ward at that time.

All the midwives I interviewed were employed as staff midwives. Some had considerable labour ward experience and were considered as 'senior', though none had a senior grade. Five midwives were less than eighteen months qualified. Thirteen worked full time hours, three worked 24 hours and one just 12 hours per week.

### **8.5 Data collection**

The interviews were undertaken between April and October 2008. Due to the high level of activity each day, it was quickly apparent that it would not be easy to conduct the interviews while the midwives were at work. On occasions when midwives had suggested I come in while they were on night duty, I called or phoned to find that the unit was too busy. I was fortunate one Sunday morning when, with the permission of the midwifery manager on duty, I was able to interview three midwives. On another occasion I interviewed three midwives who were attending a hospital based study day. The remaining interviews took place outside the maternity hospital, ten at my place of work and one in the midwife's own home. There were several midwives that I did not interview due to their inability to give me the time away from their work.

As in Phase I, participants signed a consent form (Appendix 11), interviews were recorded and field notes taken following the interview. The same ethical principles were applied. The duration of interviews varied from 40 minutes to one and a half hours.

### **8.6 Interviews Phase II**

As in the previous interviews it was easy to establish rapport with the midwives. We had a common language around birth. I told them that I was interested in learning

about their experience of midwifery in this new hospital, something I was not familiar with. As before, an interview schedule was drawn up to help guide the interviews (Appendix 12). The midwives were asked about the opening of the new hospital and their experiences of midwifery there now. In particular I explored with them if and how their practice had changed and if this impacted on their care of women in labour.

As I spent time in the labour ward, observing the closed labour room doors, I wondered about the midwives and women who were behind those doors. During the earlier interviews, the information the midwives provided to me was familiar from both my own experience of working as a labour ward midwife and also my review of the literature in Chapters 3 and 4. In this new unit, I could no longer directly identify with how the midwives were working and the data the midwives provided me with did not resonate with the previous literature. I found that I could not anticipate how the midwives would respond to my questions.

Over time, as I interviewed more midwives I found that I built up a picture of their world and experiences. This is consistent with the hermeneutic circle and I hoped it would ultimately lead me to a new understanding of how the midwives experienced midwifery in such a large maternity unit. The feedback I received from some midwives was that their perception of their environment may also have changed from having the opportunity to discuss their experiences.

The interviews were open and conversational and varied depending on the individual midwife and the responses I received. As stated previously, unlike the previous interviews, when the midwives would tell me about how busy they were; now the 'busyness' was no longer a part of their discourse; the high activity levels and throughput of labouring women was now an accepted part of their work. An additional interest was the language used by the midwives. As will become apparent, when midwives spoke of caring for women in labour, their discourse indicated that they had a greater engagement with the woman and her experience of her birth.

As before, reflective notes were recorded to capture my immediate impressions and further reflective notes were taken when listening to the interviews.

## **8.7 Data analysis**

Secretarial support was obtained for transcription of these interviews which were transcribed reasonably accurately by a professional secretarial service. Confidentiality was assured. Returned transcripts were corrected by listening through the recordings to ensure they were accurate. This was necessary because the professional language used by the midwives was not always clearly understood by the transcriber. Data analysis was undertaken over the following months.

## **Conclusion**

This chapter has set the scene of the labour ward in the new maternity hospital. It contains details on how I conducted the second phase of this study and a description of the working environment of the midwives. My early impression of midwifery in this setting was that there was considerable contrast between the old and new. It was only when I started interviewing the midwives that it became apparent how the midwives now worked. This will be detailed in Chapters 10 to 13.

The next chapter provides an introduction to the findings of this phase of data collection.

## CHAPTER 9 INTRODUCTION TO FINDINGS

Having addressed how Phase II was undertaken, I considered that the findings from this phase warranted an introduction due to the impact that the opening of the new hospital had on the midwives. This chapter thus provides a brief introduction to these findings.

As indicated in the last chapter, the differences in the physical environment between Hospital A and Hospital D was considerable. Because I spent time in the unit recruiting midwives, I observed the activity levels as midwives and doctors came by. I could see that all rooms were full and knew from the White Board that within each room was a named woman and a named midwife. It was at this stage I began to consider what might be happening in the individual rooms across from me. When visiting Hospital A it was easy to ascertain what was going on because there was always a midwife around who was aware, or could find out, what was happening in each room, and whether I would be likely to meet the midwives. This was due to the ease of movement of staff between areas. In the new unit, midwifery managers were always busy and as the key information about activity was on the White Board, asking for information was not required. I could not guess what was happening inside the individual rooms.

The use of the storm metaphor began to emerge as I started my data collection. In the initial interviews for this phase of the study, when the midwives spoke of their experiences of the transfer, the chaos of that time was evident. However, even as the midwives had adapted to their work environment, the pressure they were under persisted. This was because of the shortage of labour rooms for the number of women who gave birth there each day. The strain that this put on all staff was evident, not just in the stories the midwives provided, but also in my observations of the activity as I waited to meet with the midwives.

I have titled Chapter 10 as, 'The Storm Hits' as it aptly describes the initial turmoil midwives experienced when the hospital first opened. The following three chapters reflect the midwives' ways of working at the time the interviews were undertaken.

The first of these, Chapter 11, titled ‘Weathering the Storm (Balancing all needs)’ reflects the everyday work of the midwives as they responded to the demands of a busy labour ward where they were required to be responsive to all needs. They supported their colleagues where they could, moved between caring for low and high risk women, responded to the demands of doctors and midwifery managers and had no certainty of when they might be relieved for a meal break during a twelve hour shift. These issues were largely outside their control.

These data resonates with the findings from Phase 1 (Chapter 7) and because of this, the findings from both chapters are discussed together in Chapter 14. Data from the midwives presented in Chapter 7 reflects the impact of surveillance on the midwives which Foucault described as a Panopticon. In Hospital A, the midwives were under surveillance or alternatively, the potential for surveillance was ever present. Lipsky’s work on ‘Street Level Bureaucracy’ is also resonant. This accounts for the experience of public servants who are required to provide an equal service to all clients (in midwifery this implies individualised woman centred care), yet these public servants have little control over their environment or these resources available to provide that service. As also became apparent in my reflections on the data this had an impact on the professional identities of the midwives. This was revealed in their narratives about their work and, particularly in Hospital A, the birth stories that they related (p. 87-89). According to Lindemann Nelson’s (2001), where a group’s role is defined by powerful others, narratives of individuals within the group tend to reflect the moral agency of the group identity. Where this identity is constrained by the master-narrative of a powerful ‘other’, ‘damaged identities’ can occur. As will be discussed in Chapter 14, narratives of resistance and despair were evident in the dialogue of midwives interviewed for Phase I of this study. In the second set of interviews there were signs of a change in midwives portrayal of their identity. In the new setting, where elements of autonomy were apparent, narratives of repair emerged in their discourse. This aspect of the findings is considered in terms of counterstories and Lindemann Nelson’s work.

Chapter 12 is titled, ‘Any Port in a Storm (freedom and vulnerability)’. This explores the freedom and autonomy which was now experienced by the midwives as they cared for women in individual labour rooms, in the midst of a busy labour ward.

These data also reflect the midwives' vulnerability. Within the labour rooms, doctors or other midwives rarely visited unless at the request of the midwife. Even when midwives went on breaks, the incoming midwife did not interfere. This was a new experience. While this provided considerable autonomy for the individual midwives, they now missed the opportunities that they previously had, to consult with other midwives and discuss any concerns that they had or aspects of care. As other midwives were busy elsewhere and not available, consultation was almost always, directly with a doctor. In this environment, newly qualified midwives learnt quickly, but even senior midwives missed the opportunities to discuss care with their colleagues.

It is at this stage that the paradox of the midwives' work emerged. Previous studies, and the findings from Phase I of this study, identified the difficulties midwives have in achieving autonomy in obstetric led units. These labour ward midwives now experienced considerable autonomy in their daily work.

The following chapter develops this further and explores how midwives experience midwifery practice in these individual labour rooms in the midst of a busy labour ward corridor. Chapter 13 is titled 'In the Eye of the Storm (Midwives' territory)'. In this new unit, there were no longer norms of practice. Midwives worked largely alone and did not know how other midwives practiced. There were many labour ward policies, but no consensus in their implementation. There was little or no interference in the midwife's care and the midwives were free to decide the type of care that they would provide. The choices and decisions that midwives made reflected how they chose to enact their beliefs some it enabled nascent midwifery practices to emerge.

As will be seen in this chapter, the language the midwives used for their births stories differed from their earlier discourse around women and birth. The positive language revealed a shared experience, women were no longer passive and midwives shared in the joy of a woman's achievement when a birth went well. This reflected a new reality for these midwives. This is where the narratives of repair became apparent.

The findings about birth and, as will be seen, for from both these chapters are discussed in Chapter 15 using Merleau-Ponty's work on the existentials of perception

to frame the discussion. These four existentials, temporality, relationality, spatiality and corporeality were apparent in these data of the midwives as they described their experience of midwifery in this new large labour ward.

The next chapter describes the experience of the midwives when they transferred to the new maternity hospital, with the following three chapters reflecting the experience of the midwives at the time that the interviews were conducted.

## CHAPTER 10 THE STORM HITS

### **Introduction**

The new maternity hospital (Hospital D) opened under the spotlight of media attention. The midwives experienced anxiety as they prepared to transfer to the unit. There was considerable disorganisation in the initial weeks as supplies were still in boxes, equipment was hard to find and midwives were working alongside staff with whom they had never worked with before. The safety of mothers and their newborns was the priority in care. Midwives found that they could rely on each other, even those they did not know. This chapter explores the midwives' experience of the move and their early adjustment to the new maternity unit. I have titled this 'The Storm Hits' as it describes the chaos of the initial months. The themes, 'impending uncertainty', 'battling the storm', 'conquering the storm', and 'storm clears the decks' reflect the experience of midwives during and shortly after the move. This chapter concludes with a brief discussion on these findings.

The transfer of services to the new unit was stressful as all staff experienced considerable adjustment to their work environment. Not only were they working in a much larger unit but they were also working with new staff and had to establish new work practices in an unfamiliar setting. There were policies to guide practice and facilitate staff transition but few of these were in place at the time of the opening.

The service between the old and the new hospital was seamless and the first births took place on the day of opening. Throughout this period, I was aware of the difficulties of the amalgamation from my interaction with management and clinical staff. At the request of midwifery management, I voluntarily worked in the hospital to assist in the transfer of services. I avoided visiting the labour ward during this time as I knew that I would interview the midwives later and did not want to be influenced by what I witnessed there at this stage. The experiences of the move, as described by the labour ward midwives, were reflected in the other areas of the hospital. All areas were well staffed for the duration of the opening but much of the hospital supplies were still in boxes or being delivered during the initial weeks.



As an observer and voluntary participant in the transfer of services, several issues were apparent to me at the time. While midwifery managers had been involved in the preparation for the move, the staff midwives were less involved. The stress that all staff experienced was considerable, and this has been reported elsewhere (McLoughlin 2008). My decision to wait for twelve months before undertaking the next round of interviews was to allow time for the acute problems to hopefully resolve. This chapter consists of a description of that time as experienced by the midwives interviewed.

### 10.1 Impending uncertainty

As noted in Chapter 7, the sense of impending uncertainty was reflected when midwives spoke of their feelings prior to the move. Sandy described this as follows:

*I suppose we came out with trepidation as to what it was going to be like, being totally unfamiliar with what surroundings we were going to be facing and one or two sessions of emergency runs from ER<sup>24</sup> to the labour ward etcetera.*

*Susan (1, 10-13)*

In the earlier interviews, midwives had been vague and largely unconcerned about the move. The unrest surrounding the opening had been extremely difficult for all concerned. Sarah, who had previously told me that ‘*she was too old to change*’, now stated that she moved with a determination to adjust to the setting:

*. . . some (midwives) said they hoped to retire, that they would never go, I never felt like that . . . I went with an open mind and tried to get on with everybody.*

*Sarah (1, 41-43)*

All staff from the contributing hospitals were required to deliver the service in the new setting. Only midwives from Hospital C had a choice to remain where they were by transferring to nursing services. In considering how midwives spoke about their experience of the move, I recalled how unconcerned they had been when I had interviewed them several months beforehand. This had been prior to the conflict that had accompanied the move.

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<sup>24</sup>The Emergency Room (ER) is the name given to the area where women come for admission to the hospital if in labour or for obstetric review. Women admitted for induction of labour or elective caesarean section are admitted directly to the ward.

## 10.2 Battling the storm

The midwives provided vivid descriptions of the first few months. As data collection commenced just twelve months after the opening, memories were still fresh. They described a chaotic environment where the equipment and supplies that they needed for their work were hard to find:

*I still remember the first day, it was just horrific, it was dangerous, it was horrific, we didn't know where anything was, most of the stuff was thrown into the storerooms in boxes; it wasn't even set out on the shelves. The equipment was not in the cupboards on the shelves for us to get and we hadn't walked through sufficiently to know where everything was. It was a case of, where is the mask for this and where is the bottle for that, and searching for it and not knowing where it was kept. And anyway you were falling over boxes that had been just dumped in the stores. It was horrific and we were extremely lucky we had no disasters. There wasn't sufficient familiarisation with the establishment and not sufficient stocking up of the place so that everything was there for us to use, we just had to put our hand out to get it, it wasn't like that; it was horrific.* Sarah (1, 17-31)

Midwives had anticipated that relationships between staff would be a significant challenge, but, in reality, the greatest difficulty initially was the chaos of the poorly organised setting, where decisions were made rapidly and supplies were hard to find. This was reflected by many:

*My big worry when I came first was where to find items, ok the rooms had their wardrobes with their drawers and all you need supposedly inside them, as often happens you are asked for something that is not in the wardrobe and (you have to run) out then to the storeroom.* Susan (1, 13-16)

It was intended that each labour room would contain the equipment required to manage both routine and emergency situations. Yet for several weeks, most of the equipment and supplies were still in boxes. The midwives had to find items in response to requests from unfamiliar consultants. This was particularly stressful in an emergency or if a birth was imminent. Susan described the challenge they experienced in managing situations alongside consultants they did not know:

*. . . And ok if you have a straightforward (cases) . . . but we have had major bleeders, severe PPHs, and just finding items, and the variety of different consultants, the variety of different needs and requirements that they were used to having, not being here, you just had to deal with it and they had to get what they were given I suppose really. Happily in cases it did work out but, you know, it was luck as much as anything else in some cases.*

*Susan (1, 10-26)*

Susan was just one of several midwives who expressed concern about the safety of women and babies. Effective teamwork is important in acute healthcare settings, but this was difficult for midwives to sustain when working with staff they did not know. Difficulties mainly occurred in emergency situations and were extremely demanding on all who were involved. During this period, midwives described themselves as, just about surviving and that they felt that they were lucky that something serious had not gone wrong. As the safety of mothers and babies was a priority, one to one midwifery care was provided for each labouring woman throughout this period. During this time, some midwives resigned or transferred out of the labour ward.

Margaret, who prior to the move, had been more optimistic than some of the other midwives, described the stress:

*The first few months were stressful and chaotic all right, definitely. I suppose it took the year to kind of get settled really.*

*Margaret (1, 8-9)*

Within a few months, the equipment and supplies were essentially sorted, but this did not mean that all problems were resolved and twelve months later issues were still being addressed. This included the stocking of individual rooms, protocols for the management of clinical situations and the opening of both the Induction Room and Gynaecology Theatre.

### **10.3 Conquering the storm**

Throughout this early period, midwives relationships with their midwifery managers and the medical staff were strained. As a consequence, a camaraderie developed among the midwives as they all experienced the same difficulties and supported each other where they could. Sheila explained how this had happened:

*It was very tough, there is no point saying otherwise, I mean some days were better than others because you'd have more people to ask, and in fairness the majority of the people were very good.* Sheila (1, 22-24)

Extra staff were rostered for the transition period which helped the midwives become familiar with each other. They recognised when others were in difficulty and helped out where they could:

*I think everybody realised when some people were struggling they made the effort to be accommodating . . .* Sarah (1, 9-10)

Over time the unit became more organised:

*. . . I suppose after a month or so it got easier. You knew where things were kept, you knew your way around the place, how the beds worked.*

Sarah (1, 32-34)

Becoming familiar with their environment, where supplies were kept, how equipment worked and the requirements of various unfamiliar consultants were important for the midwives to function effectively. They supported each other where they could and while initially they did not know each other, they shared the common purpose, the safety of the women and babies in their care.

#### **10.4 Storm clears the decks**

Before the move there had been concerns as to how a large number of midwives who had never worked together would get along or whether loyalties to their original hospital would constrain them in some way. At times there were 80 to 90 midwives on the weekly duty roster, covering the day and night shifts. Midwives, who had anticipated difficulties in working with unfamiliar midwives, found that this was less of an issue than they had imagined:

*I don't think that was ever an issue for most people . . . it was never a Hospital A versus Hospital B versus Hospital C thing . . . it wasn't too bad, not as bad as we would probably have anticipated but I suppose at the same time we would all have vaguely known each other and then we had a whole load of new people coming from other places which really diluted the whole*

lot.

Sandy (16, 16-25)

In the planning for the amalgamation of services, the midwives had opportunities to meet up, particularly during their negotiations with management. During the transition, they shared the experience of general disorganisation and in order to deliver a safe and effective maternity service, this required them to support each other where they could.

Midwives were glad to receive assistance and they shared information when they could. They responded to each other in emergency situations and thus, fairly quickly, relationships among the midwives became established. Which hospital the midwife had previously worked in was less of an issue than what the particular midwife knew and if she could help out. This was expressed by Sarah:

*I think that we (Hospital A midwives) got on very well with everybody else, that (previously) people were saying, oh 'that this one couldn't get on with that one', and I don't think that actually happened . . . there is no getting mad with one another or not getting on and that sort of thing. Obviously there are always individual personality clashes but it is not 'us and them', I don't think. Yes I think mostly people get on fairly well together.*

Sarah (1, 7-14)

The midwives made efforts to support each other where they could.

The large number of midwives meant the opportunities to get to know each other well was limited. Lucy, who had returned to midwifery after several years' absence, was still getting to know the other staff:

*I did (a) 'back to midwifery' (course) last year and it was a great time to go in (six months after opening) because they had made the move, they were all starting to get settled together, I mean I couldn't even tell the difference between where the midwives came from. I knew some of the midwives from Hospital A and some from Hospital B, one or two from Hospital C but I couldn't have told you all of them, and I suppose that was a good sign.*

Lucy (1, 25-30)

Similarly Michele, who had been on leave during the move, appreciated that a degree of organisation had taken place by the time that she returned to work:

*I suppose my experience coming out here was good enough because the place was running for six months by the time I came back from maternity leave. So when I asked somebody where something was, everybody knew it, it wasn't everybody not knowing where everything was, there wasn't that stress about it*

*Michele (1, 7-11)*

One year after the opening, practice issues and procedures were still being addressed:

*there were loads of settling things going on and there still is, I mean every so often there is a pepping up to go to this meeting and to get some things sorted out*

*Lucy (1, 32-34)*

It took a while for the staff to become sufficiently familiar with their environment and their colleagues to enable them to work effectively and efficiently as a team. During one visit to the unit I witnessed a senior midwife consulting a policy for the management of a woman with Group B Streptococcal infection and spontaneous rupture of membranes. Two relevant policies that were found which appeared to contradict each other. In the end a doctor was consulted to resolve the issue.

## **Conclusion**

When the chaos of the move had settled and the staff became familiar both with their environment and the people that they worked with, the midwives adjusted into new modes of working. Over the first several months, equipping of the unit was organised and procedures became more defined. As a consequence, when I interviewed the midwives for this phase of the study, the commonalities of their experience were apparent from their dialogue. The phrase the 'The Storm Hits' described the chaos experienced by the midwives in the initial months following the opening of the new unit. The themes outlined in this chapter, 'impending uncertainty', 'battling the storm', 'conquering the storm', and 'storm clears the decks' reflected the shared experience of midwives during this time.

The impact hospital mergers have on health care workers has been previously

reported, and both organisational support and management styles are considered as important factors in successful adjustment (Barry-Walker 2000, Armstrong-Stassen et al. 2001). As noted earlier, the stress, that these midwives experienced throughout the period, has also been reported (McLoughlin 2008). Laschinger et al (1999) found that during periods of transition, the leadership behaviours of managers significantly influence employees' job tension and work effectiveness. The midwives I interviewed, blamed doctors and midwifery managers for many of their problems. As the period of transition was not the focus of this study, the findings of this chapter are not discussed further. The purpose of providing these data here is to describe the background experience of the midwives I interviewed. All but two of the seventeen midwives were working in the labour ward at the time of the move.

This chapter has described the experiences of the midwives as they made the transition from their old units into their new work environment. The following three chapters provide an account of the lived experience of the midwives as they experienced midwifery in this setting. Themes which will be explored in the next three chapters are 'Weathering the Storm', 'Any Port in the Storm' and 'In the Eye of the Storm'.

## CHAPTER 11 WEATHERING THE STORM (BALANCING ALL NEEDS)

### **Introduction**

The interviews were undertaken twelve to eighteen months after the amalgamation of the three maternity units. By this time, the large number of both experienced and inexperienced staff had learnt to work together to deliver, what was now the only maternity service for the region, and one of the biggest in Europe. The hospital had been built to accommodate 7,000 births per year, but, as stated earlier, in the year that the interviews were undertaken, there were almost 9,000 births. The data presented in this and the next two chapters reflect the midwives' experience of working in this labour ward at the time that the interviews were conducted.

The first theme for this phase of the study is termed 'Weathering the Storm'. The storm metaphor continued to be relevant as the activity levels associated with the number of women who gave birth each day continued relentlessly. With just eleven individual labour rooms and 20 to 30 births each day there was pressure on the midwifery manager to manage the space so that rooms were available for women as required. Each weekday there could be ten or more women booked for induction of their labour; these women were admitted throughout the day as rooms became available. Towards the end of the period of data collection, the five bed induction room opened. This eased demand on the individual labour rooms but became another area that required an allocation of midwives. In this setting, the midwives were required to balance all needs and thus it seemed that they had learnt to 'weather the storm'.

Once over the early period of adjustment the staff midwives settled into patterns of working which, at the time of these interviews, were still quite new for them. Old hierarchies and previously established ways of working no longer applied. The midwives tried to deliver a quality service where they could. They were required to provide individualised care for women in labour while at the same time responding to the diverse needs of the unit. This might involve responding to a call for assistance by another midwife, clearing of a room quickly after a birth, or being sent by the midwifery manager to work in another area as required. This was often



without the certainty of regular meal breaks during their twelve hour shift. This theme will be explored under the following headings ‘going with the flow’, ‘never ending swell’, ‘the epidural question’, ‘contested priorities’ and ‘clearing the decks’. As mentioned previously, much of the data presented here resonates with Lipsky’s Street Level Bureaucracy.

### **11.1 Going with the flow**

The large throughput of women required midwives to be flexible in all aspects of intrapartum care. This was now a tertiary level maternity unit and midwives met an increasing number of women experiencing complex pregnancies. Women were referred to this hospital from other from other parts of the country for specialist obstetric care or in anticipation of the need for tertiary level neonatal care for their babies.

*. . . we get high risk people from all over Ireland now, which we didn’t get before - twins that have anomalies<sup>25</sup>, complex preclampsics<sup>26</sup>, so we are seeing people now from Galway, from Kilkenny, Waterford, Wexford and so on . . .*  
*Sandy (14, 4-17)*

On any day, midwives were expected to care for low or high risk women in labour. The midwives felt that they had to be skilled to work in the operating theatre, recovery or the high dependency unit as required. The high epidural and induction rate, private obstetric service and more complicated cases provided challenges to midwives who could be allocated to the care of any woman or any area at the start of their shift.

Rose explained how the midwives began their day:

*1 to 10 (midwives), the staff that are present for the day are in front of our ward sister, the night sister would (provide a) handover to the ward sister and as each room, from 1 (to 10) (is discussed), a midwife (is allocated) to that room and takes a more detailed handover from the midwife inside the room. So you stay there then until that lady is delivered . . .* Rose (8, 33-37)

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<sup>25</sup> Congenital abnormalities or divergent growth of the twins

<sup>26</sup> Refers to pre-eclampsia a hypertensive disorder of pregnancy

The midwives had become used to the labour ward filling up quickly each morning and the rooms were seldom empty for long.

*On an average day the ten rooms are full, theatre is going all the time*

*Ann (12, 13)*

Barbara, who often worked the night shift, explained that the midwives had to be prepared and willing to work in all areas:

*we cover the High Dependency Unit and we cover the labour wards and we cover the Induction Room, and the theatre at night time . . . it puts a huge pressure on the staff. . . if theatre is running late this impinges on night duty staffing levels and then if the High Dependency Unit is full, that takes a certain number of staff. If the labour ward is full, and if the Induction Ward is full, it takes (midwives) all the time . . .*

*Barbara (1, 22-30)*

While the midwives knew that the rooms in the labour ward was almost always occupied, each day or night was different and when a midwife came on duty she could not anticipate how she would spend her shift.

One to one care was the norm, but occasionally a midwife would look after two women; Elaine, a recently qualified midwife informed me about how this was challenging for her:

*I had a lady who was IDDM (diabetic),<sup>27</sup> a primigravida on Syntocinon, the whole works, epidural, so it wasn't as bad as that. But then I was asked to take another lady who was a multip,<sup>28</sup> there was a student inside and I looked in and examined her and she was fully (dilated),<sup>29</sup> so I suppose you are sort of rushing between two rooms and it is not as nice.*

*Elaine (5, 13-17)*

The lack of support for junior midwives will be explored in the next chapter and also how midwives described births where they provided one to one care.

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<sup>27</sup> A woman with insulin dependent diabetes mellitus (IDDM) requires extra vigilance in labour due to the potential for complications.

<sup>28</sup> Multip refers to a multiparous woman i.e. a woman who has given birth at least once before.

<sup>29</sup> The woman's cervix was fully dilated which indicated that she had commenced the second stage of her labour and the birth would be imminent.

The shortage of labour rooms was an on-going issue and midwives were aware when women were waiting. This was particularly a problem before the Induction Room opened:

*Certainly the induction list . . . if there is no bed for them, you are aware that they (the women) are waiting to come down . . .* Rose (8, 3-5)

When I asked Rose how this impacted on her work she told me that while midwives were not under pressure to hasten labour, once the baby was born they were aware of the need to vacate a room:

*. . . when she has delivered there might be a bit of pressure . . . to get things wrapped up and once the mother is fine and baby is fine as well and you have a quality feed established, but you'd be actually getting the lady upstairs to facilitate the distressed lady . . . (waiting for the room)* Rose (8, 8-13)

This was also mentioned by Edel:

*. . . you could be told that you are taking (too much time) there is another lady and to hurry up, have her (the new mother) out of the room.* Edel (16, 9-10)

The midwives resented the rush to transfer women to the postnatal ward:

*you feel you are rushed (after a birth) there is a lot of paperwork to get done . . . I suppose (midwives) still do the skin to skin<sup>30</sup>, it is done, but you are inclined to be a bit more rushed . . . you would be conscious that you have to move (the woman) or that someone else is coming down. Whereas on a nicer day you mightn't have that rush, the room mightn't be in such demand and it is a bit easier to do it (skin to skin care).* Margaret (3, 20-26)

When the midwives were under pressure to vacate a room, it appeared that 'skin to skin' care could become just another task, one of several procedures, midwives were required to perform.

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<sup>30</sup> Skin to skin care postpartum is a WHO recommendation to support breastfeeding and mother and infant attachment. Feeding should be initiated within 30 minutes of birth prior to transfer of mother and baby to the postnatal ward

Midwives only spoke of being rushed when a birth was complete. At other times, as Mary stated, '*there is no rush*' (3, 1). This was an important finding in this study and will be explored in more detail in Chapter 13. Despite the shortage of rooms, midwife repeatedly stated that there was no pressure to hasten the birth. Claire was the only midwife who admitted, that on a day where women were waiting for a room, she might find herself:

*. . . encouraging them to have an ARM, moving the process along. You start thinking . . . the beds are kind of tight. Now it is not that they (midwife managers) are coming into us and saying, 'are you nearly delivered there yet', it is not that. But it just does impact on how you think a little bit. And when you get into a phase . . . of working fast, doing a lot of quick deliveries, you have to take a step back until it slows down and that is not good that you have to think about that.*

*Claire (3, 40-41; 4, 1-5)*

Most midwives were allocated to a woman in labour at the start of their shift but Claire often remained outside in order to assist other midwives as required. As a consequence she reported that:

*I can end up doing two or three deliveries a day . . . I can also end up looking after somebody for 12 hours.*

*Claire (5, 38-39)*

Claire was conscious that she hastened some women through labour because of an awareness of the shortage of rooms. She had to remind herself when this was not necessary. All the other midwives informed me that while the woman was in labour, there were no time limits on the duration of labour. The pressure commenced when the birth was complete.

During the day, the theatre and labour ward staff worked closely together, with particularly the medical staff moving through each area according to need. Midwives were aware of the activity in theatre as they sometimes had to wait for an anaesthetist to provide an epidural. At night time the labour ward midwives covered the obstetric theatre. The constant flow of women and the shortage of staff to cover all areas put pressure on the midwives, but when they spoke about the workload on the unit and how this impacted on them in terms of having to vacate a room quickly after a birth and also not getting their meal breaks. Few expressed their feelings

about this and most spent their shift within the rooms, caring for individual women. How they felt about this aspect of their work will be reflected in the following chapters.

Getting time for meal breaks was an on-going difficulty and was raised as a problem by many:

*we are barely getting through a day, the midwives are suffering a lot in terms of not getting regular breaks . . .*

*Sandy (14, 7-9)*

This was what made a good or bad day:

*Some days are great and some days are terrible. And when you are not getting your lunch . . . when you don't get your lunch until 4:30, it is exhausting, it doesn't happen every day but it happens a lot . . . you take your lunch, you sit, you eat, and you go . . .*

*Patricia (17, 25-31)*

These contrasting experiences of 'great' and 'terrible' days were interesting and reflected issues that were important for the midwives during a twelve hour shift. When they were not relieved for their breaks, they complained. The more positive aspects of what made a 'great' day will be explored in the next two chapters.

Rose told me how midwives organised work to manage breaks:

*We have no lull . . . So by your cup or tea or your lunch break . . . you have to be organised, you'd mind someone else's lady and they in turn (would) mind your lady.*

*Rose (7, 14-21)*

At times a woman could be left unattended:

*Occasionally . . . you could pop out and get a drink for five minutes.*

*Sandy (14, 19-20)*

Midwives provided one to one care of the woman in labour, sometimes accompanied by a student midwife, but two were required to be present for a birth. When a birth was imminent the midwife would summon assistance using a call bell. Others responded promptly if they could:

*we have been kind of socialised to keep our ear to the bell, when it rings . . . if it is left or right of you there is a general consensus, you need to go and help that person if you were in a position to . . . It can be a bit of a Piccadilly Circus scenario because four or five people can end up all bounding through the curtain at one time and the women is giving birth normally. There are a few things like that need to be fine-tuned still! Sandy (5, 15-23)*

Midwives had not yet developed a system of who should respond to a call bell, but as with meal breaks, some organised this among themselves. They anticipated when assistance would be needed by monitoring the White Board:

*. . . every time you go to the (White) Board to put your lady on . . . so that people will know when they look at the board when the bed is free or that she is ready to deliver . . . So you look at the Board and you say, 'oh they are pushing and when the bell goes I'll know she wants a midwife in the room'. Patricia (12, 18-23)*

The midwives were aware that the White Board was also used by the midwifery manager would know when a birth was complete. From this time on they could be encouraged to vacate the room.

## **11.2 Never ending swell**

The midwives railed against the issues that were most demanding for them. As in the previous interviews, they described the approach to labour as being actively managed:

*Very active management now . . . it is very active of course it is, we have over 8,500 births a year and we have 11 rooms . . . So, yes, it is very active. Patricia (12, 6-15)*

As previously (Chapter 7), the midwives used the term active management loosely and, as Elaine informed me, the management of labour in this unit did not adhere to

the Holles Street model<sup>31</sup>:

*. . . it is not 'actively managed' here supposedly . . . I think it is still quite medicalised, it is still pretty much the same as Holles Street. They might not call it 'actively managed' but I think it probably is. Elaine (2, 6-8)*

Having been a student midwife in Holles St, Elaine went on to describe some of the differences between the management of labour in the two hospitals. Prior to working here she had not witnessed a woman in labour with her membranes intact or, as she described it, '*such long labours*'. In Holles St, the birth rate at just under 9,000 births per year was similar to this unit.

The number of women coming for induction of labour was a topic frequently raised. Edel checked the number of women booked for induction at the start of her shift:

*. . . it is just nice to see is it 12 is it 10, or 8, but when you start in the morning you'd go into your own room . . . the (White) Board mightn't necessarily be full and then at 11 o'clock the whole place would be heaving and (caesarean) sections and stuff like that . . . Edel (7, 13-21)*

There was much discussion about the level of inductions among the midwives and the issue of them feeling powerless to effect change resonated with my earlier data:

*There are a lot of midwives but we seem to be completely powerless because we don't seem to have any sway with the management and we have discussed it with our own line managers on a regular (basis) ... I have often said, why are we allowing these inductions? Claire (16, 23-25)*

Unlike the earlier interviews in Hospital A, the midwives could now voice their disquiet, even if they felt that nothing was being done, they seemed to be aware that they had some responsibility in addressing this issue. They were particularly concerned about the justification used for some inductions:

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<sup>31</sup> The National Maternity Hospital in Dublin is colloquially referred to as 'Holles Street' which is the street on which it is located. Active Management of Labour (O'Driscoll and Meagher 1980) originated here and the protocol is maintained for routine management of labour (Boylan, 1997, Impey and Boylan 1999, O'Driscoll, et al. 2003). The evidence supporting this approach has not been replicated in other studies and has been critiqued for having a greater focus on the management of time and space in large hospitals rather than meeting the needs of individual women (Hunter 2003)

. . . (no doctor) sticks to term plus 10<sup>32</sup> and there are a load of dubious reasons for the inductions, reduced AFI (amniotic fluid index)<sup>33</sup>. How can I argue with that? . . . even though when I do an ARM I might get drowned. It is very hard. A certain group of consultants definitely believe that women, once they are term at all and they are suitable for ARM, let's go for it, what are we waiting for!

Claire (12, 22-28)

The previous experience of midwives feeling powerless had led to acceptance and compliance with the *status quo*. Unlike in Hospital A, midwives voiced concerns about the indications for induction and they also considered that this contributed to the caesarean section rate. As Ann stated:

*Indications for induction vary with everybody, you'd see women coming in at 38 weeks. I had a women . . . they brought her in at 38 weeks, induced her, she ended up having a (caesarean) section . . . (a woman) came in yesterday for induction and ended up sectioned that night, after three (previous) vaginal deliveries . . . She was term plus 5 or 6.*

Ann (5, 18-27)

Margaret, when previously interviewed had not criticised their practice of others, now commented:

*there are a lot of consultants around and I don't think there is anyone overlooking what they do . . . you see that every day, this (woman) is a day or two overdue and is induced . . . they end up with a (caesarean) section, they just probably weren't ready in the first place.*

Margaret (5, 3-9)

During the day, managing and providing care for women being induced was a large part of the activity of the midwives:

*I suppose 60%-70% of the women you look after on days are inductions whereas at night it is spontaneous labour.*

Sheila (2, 33-35)

This was repeated by several midwives:

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<sup>32</sup> The hospital policy for post term pregnancy was to offer women an induction of their labour ten days after her expected date of delivery (EDD).

<sup>33</sup> Reduced amniotic fluid, measured as an amniotic fluid index (AFI) is an indication for induction of labour. In this scenario when the amniotomy was performed the liquor volume appeared ample.



*I don't know what the incidence of spontaneous labour is compared to inductions but I'd say the induction rate is very high and they (the women) all come down and they are all tensed up. And they are all looking for their epidural.*

*Sarah (3, 21-24)*

The main difference between the day and night shift was that with eight to twelve women for induction each day, there was an increased likelihood of caring for women in spontaneous labour during a night shift. The issue of women looking for 'their epidural' will be discussed in the next section.

According to the midwives the high induction rate contributed to the requests by women for epidurals and they linked both interventions to private obstetric care:

*And there are more epidurals because there are more women being induced . . . because of private (obstetric) care Monday to Friday, the (consultants) are off at the weekends . . .*

*Claire (5, 32-35)*

Midwives preferred to care for women in spontaneous labour and even where women were induced, the midwife might manage the woman's care without any interference. As Ann informed me:

*Doctors seem more interested in the inductions and if they feel that you are happy that the woman is progressing, they are happy most of the time to leave you to it.*

*Ann (2, 31-33)*

Though the midwives complained to midwifery managers and doctors about the number of women admitted for induction each day, there was little that they could do about this other than to complain when the opportunity arose. This was in contrast to the data collected in Phase I, where the midwives experienced difficulties in voicing their complaints (p. 87-88).

### **11.3 The epidural question**

The other issue that greatly concerned the midwives was the level of epidurals, and, again they linked these to instrumental births. Lucy took an opportunity to explore the epidural rate for herself:

*I just decided one day I would look up the previous 100 births and out of the 100 births there were 85% epidurals and out of that 85% epidurals more than 50% ended up instrumental<sup>34</sup> or caesarean.* Lucy (3, 19-20)

Mary, a junior midwife, categorised women into those who expected to have an epidural for labour, and those who were looking for, or were at least open to the possibility of a more natural birth:

*. . . the type that come down for induction and the type that are spontaneous. Now you kind of know the spontaneous ones that will do 'it' (have a natural birth) and the ones that won't do 'it' (labour without intervention), you just kind of know. So the induction ones, they come down . . . and you just know with the Syntocinon they are not going to go the whole way so I always advise the epidural.* Mary (6, 29-35)

This applied to women in spontaneous labour and also those having their labour induced:

*. . . And they are all looking for 'their epidural', even the women who come in, in spontaneous labour look for the epidural.* Sarah (3, 16-19)

As with labour inductions, this was perceived to be more common for women who had private obstetric care:

*Some of the primigravidas are told (by their consultant that) the minute they get a pain 'to come straight in and demand your epidural' before you have even had an examination to know whether you are in established labour or not.* Susan (3, 8-11)

As will be discussed in Chapter 13, midwives had various methods of managing requests for epidurals and if there were opportunities to discuss alternative methods of pain relief, this was done. However, for the women looking for what was described as, 'my epidural', the midwives obtained this when requested because, as Sheila stated:

*a lot of them want, 'my epidural' as they call it, and you don't want to be seen*

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<sup>34</sup> Refers to a forceps or vacuum delivery

*to be talking them out of it.*

*Sheila (2, 20-21)*

This was reiterated by Patricia, who admitted to changing her practice on this issue:

*. . . if that is what they want you are not going to talk them out of having an epidural. There was a time when I used to think I could, but they give you no thanks for it.*

*Patricia (6, 11-14)*

Midwives had received complaints when an epidural was not provided when requested and this reflected badly on their care:

*It is a difficult one because we have had women complaining . . .*

*Sandy (10, 24-25)*

As will be seen later, the woman's judgement on the midwife's care had gained a pre-eminence that had not been apparent in the earlier interviews. When an epidural could not be obtained, it could be distressing for both the midwife and the woman. Sarah related this experience:

*I spent half an hour looking for an anaesthetist while this woman is in strong established labour. And I go back because I can't get anyone and 5 or 10 minutes later she has the baby. Now I spent all that time looking for an anaesthetist . . . I just said, 'I couldn't get anyone, sorry, I tried'.*

*Sarah (5, 35-41)*

Though the midwife's role is to support women through labour, Sarah spent time away from this woman when her labour was progressing rapidly. Because an epidural was not available this was an unsatisfactory experience for both.

Giving birth without an epidural was valued, but in some situations, midwives would suggest to a woman that she should avail of one, principally where labour was perceived to be particularly difficult:

*. . . it is difficult when they are in so much pain to not advise them about the epidural . . .*

*Mary (6, 21-22)*

Mary would suggest an epidural if she considered that the woman would not cope well, particularly where labour was induced or if an instrumental birth was

anticipated:

*. . . I always advise the epidural, I tell them that it (induced labour) is a long labour, I examine them first and I talk them through it and that it is a long labour and that while I'd appreciate they'd like to go as far as they could, sometimes they can get so exhausted, you are not able for the pushing and it ends up then that you have an assisted delivery. Mary (6, 35-38)*

For Mary, epidurals were associated with labour inductions and she noted with surprise when one induced woman gave birth without one:

*We had one lady who sat on the ball for the whole night and she had her Syntocinon and she got to fully (dilated) and she needed no epidural . . . but she did it. Mary (5, 40-42)*

It must be noted, Mary was the most junior of the midwives I interviewed.

Despite the prevalence of epidurals and midwives declared preferences in caring for women without one, this was not something they could decide for themselves and all stated that they were prepared to care for all 'types' of woman. Elaine expressed the views of many by saying:

*It doesn't make a difference, if she really, really wants (an epidural), personally I prefer doing a delivery without one, I think it is easier, the day goes much quicker but it depends what (the woman) wants, if she is adamant that she wants an epidural then I have no qualms, I will give it to her, we'll organise it. Elaine (4, 26-29)*

For Elaine, and for all the midwives, there was greater satisfaction in providing care to women without an epidural. Strategies midwives used to steer women away from epidurals will be explored later.

#### **11.4 Contested priorities**

During the period of data collection, the midwives were under pressure to open the Induction Room to ease the demand on the individual labour rooms and the two rooms in the unit that received least attention were the Home from Home Room and

the Pool Room. Both are situated at the end of the labour ward corridor adjacent to theatre and the High Dependency Unit (Appendix 2). Shortly after the hospital opened the sofa in the Home from Home room was moved to the staff tea room to make space for a resuscitaire<sup>35</sup>. This space had thus turned into a conventional labour room. Ann was quite disparaging about what had happened:

*It has all the (standard) equipment, sure a home from home? What is a bit of timber? . . . (It was intended to) leave (the resuscitaire) out in the corridor and bring it in if you thought you might need it . . .* Ann (14, 14-16)

Sandy reiterated this dissatisfaction and explained how this particular room was now disliked by the midwives:

*it is a busy regular room now, it was never built for that sheer volume of equipment . . . everything is in there now, a resuscitaire and CTG . . . I use that room in the same context as I use every other room because I don't think there is any difference now . . . we don't even like it as much as the other rooms because it is smaller. It has just become Room 11 and it is really busy and you have people coming in there for ARM and Syntocinon as well.*

*Sandy (14, 26-37)*

Though the décor in the Home from Home room was less clinical than the other labour rooms; this room was now equipped the same as all the others. Barbara informed me that there was no impetus for the room to be used differently from the conventional labour rooms:

*I always said when I heard it was down the end of the corridor (near theatres) it would never be used for what it was supposed to be used . . . it is not suitable anyway . . . It is too small, it is too narrow, there is a bed in there . . . there was no will behind that room as a Home from Home room.*

*Barbara (14, 12-38)*

Barbara was disheartened by this and contrasted what had happened to this room with the pressure the midwives had been under to open the Induction Room:

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<sup>35</sup> A resuscitaire is a large open platform designed for the examination of the newborn and equipped for neonatal resuscitation

*the Induction Room came on board without any (discussion), it (the number of inductions) was supposed to be audited for months, now it (the room) is up full and running without any auditing or communication or discussion or anything*  
Barbara (15, 8-10)

The Pool Room was the only unused room in the unit and at the time of data collection this space was used for storage. The issue came up in several of the interviews with various responses. There was uncertainty as to whether it would ever be used for the purpose intended:

*I don't think it will be up and running until we get better staffed . . . that room is there and it is not used for anything else really, you know, a bit of stuff stored in there but I just can't see it taking off*  
Sandy (14, 6-23)

None of the midwives interviewed had any experience in the use of a birthing pool and their dialogue reflected some uncertainty about its use. Ann was one of a few midwives who expressed positive views about the room but was sceptical about it ever being used:

*I can't see it used . . . none of us have been trained, but nothing is being done to train any of us . . . there are obviously midwives that have used them abroad so . . . It is never even open for discussion . . . it will be gone, and it such a fabulous room . . .*  
Ann (14, 1-9)

Elaine stated that she would like to be able to offer the pool to women in labour but was cautious about using it for a birth:

*I would use it without a doubt . . . It is such a good facility and obviously I wouldn't be too keen in delivering, you are not allowed to do it anyway, but I think it would be a lovely idea to have it (for women in labour)*  
Elaine (9, 6-9)

The pool has recently become available for pain relief in labour but women are required to leave the pool prior to the birth. Training for the midwives has since been provided.

## 11.5 Clearing the decks

While within individual rooms the midwife worked alone, this was in the midst of a unit where 20-30 births or more occurred each day. Where possible the principle of one to one care was maintained throughout this period. This was evident from all the interviews and confirmed by the midwife managers I met. If there was a shortage of midwives, a student midwife might be given the care of a suitable woman in labour; the midwife in charge would take responsibility for the woman and would be in and out. Alternatively, student midwives replaced midwives for their breaks and assisted in the transfers to the postnatal wards.

The hospital had a range of evidence based guidelines for obstetric and neonatal care, and the midwives made efforts to provide best care and also follow hospital protocols. While the midwives criticised the high level of labour inductions, they worked closely with obstetricians, anaesthetists and neonatologists and valued the multi-disciplinary nature of their work. Barbara acknowledged the ideals of the new unit and explained what she perceived this to be:

*Well (the workload) continues but who is going to say that you are not going to get maximum care and best of practice, I mean that is what your unit aims to do. The guidelines are there, all the reports are there, there are so many reports looking at communication, consultation with your staff. And I know there is a lot written about midwives in conflict with obstetricians but it has to be multi-disciplinary, it has to be, and there has to be that level of respect.*

*Barbara (15, 25-30)*

The shared goals of midwives and doctors, and the requirements for best practice meant that, as far as Barbara was concerned, each had to respect each other's skills and expertise. This trust between midwives and obstetricians was not reflected in the earlier interviews.

As was evident from the previous chapter, the midwives now worked well together and again, in contrast to the experiences of the midwives interviewed previously, there was greater acceptance of different ways of working:

*you work with different people all the time . . . I must say I found myself very*

*adaptable . . . I suppose the more you work with people the more you do get to know their idiosyncrasies and they get to know mine as much.*

*Susan (1, 32-37)*

Working together referred to being present at a birth or when dealing with an emergency. These were the only times that the midwives now worked together. As will be seen, midwives now used various positions for birth and variations in practice were now accepted. Though some midwives referred to hospital policies, there no longer seemed to be the consensus of care which had been evident before the move. This will be explored further in later chapters but as Margaret explained:

*. . . there are still issues, but overall I think people gel as a team, as a group of midwives, some people might disagree but overall I think so.*

*Margaret (1, 9-11)*

One year after the opening, the midwives had adapted to new ways of working and had settled into their new maternity hospital.

## **Conclusion**

This chapter has provided an account of how the labour ward midwives had adapted to the different ways of working in this new labour ward. It has described how they managed and organised their work and how they dealt with issues that were of concern to all. The number of women coming for induction each day was a problem as it led to pressure to vacate rooms quickly following a birth. They complained about this and expressed frustration that nothing was being done.

Because of the number of women coming for induction each day, the midwives had been under pressure to open the Induction Room, yet the Home from Home Room had been converted into a conventional labour room, and at the time of the interviews, there was little enthusiasm for the Pool Room to be opened.

Unlike the midwives interviewed previously, the midwives now complained about the issues of concern to them such as the number of ‘inductions’ and not getting their meal breaks. While they felt that, nothing was being done (p. 126), previously, in Hospital A, midwives did not raise their concerns. How the midwives experienced



practice within the individual labour rooms will be explored in the next two chapters.

This chapter considered the challenges for the midwives working in this large maternity unit. The sub-themes identified here were 'going with the flow', 'never ending swell', 'the epidural question', 'contested priorities' and 'clearing the decks'. The everydayness of these data resonates with Lipsky's street level bureaucracy and highlights that, as with other public sector workers, the midwives had to adapt to their environment and provide 'best care' with little control over their working conditions and the number of women who would come to the labour ward each day. The issues of power and control, and consensus of care, which had been very evident in the earlier interviews, were not now apparent in the dialogue of these midwives. There was little diversity in this aspect of midwives' description of this world. The stresses and difficulties were shared and the findings from this chapter will be discussed further in Chapter 14.

## CHAPTER 12 ANY PORT IN A STORM (FREEDOM AND VULNERABILITY)

### Introduction

Having explored how midwives coped with the demands that were made on them in a large and busy labour ward, this chapter will focus on the midwives' experience of caring for women within the individual labour rooms. As became apparent in the last chapter, the general workload of the unit impacted on all the staff, but once a midwife entered a room she escaped from the activity outside. If everything was straightforward in a woman's care, doctors and other midwives were not involved and were unlikely to visit unless requested. This is in contrast to the midwives interviewed previously who spoke of 'interference' as they could never be sure that a doctor or other midwife would not become involved in a woman's care (Chapter 7). In the new unit, interference did not happen; the midwives had greater freedom, and, as will also be seen, they now had autonomy in their work.

A negative aspect of this environment was that midwives could feel isolated within the room. Where formerly there were opportunities to consult with each other, now, as all midwives were fully occupied, if a midwife had any concern, doctors were approached first without discussing the need for this with another midwife. The isolation of the individual rooms enabled them to work with greater freedom and autonomy, yet also made them vulnerable and potentially insecure.

Thus, the next theme that emerged from the data I have titled, 'Any Port in a Storm (freedom and vulnerability)'. The midwives interviewed, appeared authentic in their descriptions of how this was experienced by them, and this theme ran through much of the data. While the sense of insecurity was more apparent in the dialogue of junior midwives<sup>36</sup>, experienced midwives stated that they had little opportunity to discuss aspects of care, or to help more junior staff with decision making. The limited experience of the junior midwives was largely overlooked.

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<sup>36</sup> The five midwives who had less than 18 months experience in the labour ward were Edel, Rose, Sheila, Mary and Elaine. Elaine was the only one of this group who trained outside the parent hospitals (Hospital A and Hospital B). Mary and Sheila had not worked in the labour ward before the opening but Edel and Rose had worked as labour ward midwives in Hospital B.

Midwives welcomed the autonomy afforded to them by the private rooms as it enabled them to practice the type of midwifery that they enjoyed. This chapter explores the experience of midwives working within the individual labour rooms. The subthemes are, ‘island in the storm’, ‘sink or swim’, ‘cast up on the rocks’, ‘your own lady in your own four walls’. How this experience impacted on their practice as midwives will be further explored in Chapter 13.

### **12.1 Island in the storm**

The isolation that the midwives encountered in the labour rooms in the new unit was probably the biggest challenge they faced. In Hospital A and Hospital B, the space where the midwives had worked was interconnecting and thus the midwives were never truly alone (Appendix 2). It was a new experience for them to be on their own with a woman in labour all day and have full responsibility for her care. Doctors could do rounds to review progress, but they too were caught up in the workload, and, as a result, medical rounds did not always happen. As Sarah, and several other midwives, informed me:

*you are isolated in the room on your own, there is no coming and going . . .  
you are very much on your own . . . and you just get on with it*

*Sarah (2, 18-21)*

Doctors and midwives no longer wandered in unannounced. This was reiterated by many midwives. Once allocated to a woman in labour, the midwife would enter the room which, as will be seen in the next chapter, was a sheltered space that operated a rather different temporal rhythm:

*you would be with the same woman all day long and you may never leave  
that room*

*Barbara (13, 35-36)*

Lucy described this experience:

*what is going on in that room is that that midwife and that woman in the most  
case are there together and they are not disturbed, they are really not  
disturbed. I am so rarely disturbed by another midwife or anything else*

*Lucy (2, 7-9)*

The previous chapter explored how the midwives adjusted to the workload in the new hospital and the pressures and frustrations that they felt. In this setting, they also had to adjust to working independently and providing care for women with various needs, or various levels of 'risk'<sup>37</sup>, without the reassurance of support from other staff.

At times the isolation caused anxiety, but the midwives also enjoyed the freedom that this lack of surveillance brought. Sarah expressed this paradox, being glad of the privacy for the women and the autonomy for the midwives, while at the same time, regretting a lack of opportunities to discuss aspects of care with her colleagues:

*The room is grand, it is a bit isolated, (previously) there was camaraderie with others, more referring to others, 'what do you think of this CTG' or 'what do you think of that?' There is very little of that now and you are on your own with the woman all the time and there is no referring to others (midwives) for an opinion.*

*Sarah (2, 13-16)*

When midwives spoke of isolation it was always in relation to concerns that they had about individual women. Previously there were opportunities to discuss any concerns with another midwife prior to consulting the doctor.

Two midwives were required to be present at a birth but as Sandy expressed:

*. . . (midwives) are fairly scarce on the ground. Most of the time when you call somebody for delivery they will just come for the delivery and, as soon as it is done, they are gone. You'd miss the help . . .*

*Sandy (6, 28-36)*

Midwives could not always rely on assistance being available:

*. . . if somebody rings the bell, midwives have said that people would not (always) come to them and I guess that is frightening if somebody doesn't come and you are in a situation . . .*

*Barbara (1, 34-36)*

Occasionally midwives were required to manage a birth on their own and if all was

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<sup>37</sup> Pregnant and labouring women may be categorised as 'low risk' or 'high risk' according to various criteria. Women categorised as 'high-risk' receive greater monitoring and surveillance due to the possibility of complications occurring. If complications occurred during labour an instrumental birth or emergency caesarean section may be required.

straightforward this was not a problem. However, the uncertainty about whether someone would be available when needed impacted on the midwives in various ways. Barbara tried to anticipate problems where she could:

*I would always ensure if I had a problem . . . (but) that comes with experience, that if you anticipate a problem you have to ensure that you have somebody with you before you ring the bell that you need to have somebody there with you.*  
Barbara (1, 36-40)

Previously concerns would be discussed with the senior midwife on duty. Now midwives contacted doctors directly and they relied on them to respond quickly:

*a doctor will come in if you are worried . . . they always come straight away so there is good enough support there.*  
Mary (2, 2-10)

Mary was confident that a doctor would be available but as Barbara stated, this was not a certainty:

*At times you may go out and there may not be anybody available.*  
Barbara (1, 40-41)

Lucy described how events outside the room could change quite rapidly which was a problem if assistance was needed:

*. . . And the labour ward just took off at that point in time, there was two (caesarean) sections going on, cord prolapse<sup>38</sup>, triplets, so I wasn't getting any doctor help.*  
Lucy (5, 41-42)

Fortunately, the problem Lucy encountered resolved and in this scenario, all turned out well for the mother and baby.

## **12.2 Sink or swim**

Either because of, or despite, the relative isolation of the room, the junior midwives were surprisingly confident when they spoke about their work. They admitted to enjoying the challenging aspects of this, rather than acknowledging any lack of

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<sup>38</sup> A prolapsed umbilical cord requires an emergency caesarean section if the baby is to survive. It can occur when an amniotomy is performed and the fetal head is not engaged in the pelvis.

confidence or displaying any vulnerability. Mary, who was just six months qualified and the most junior midwife interviewed, had requested to work in the labour ward. She appeared to have thrived in this environment, using positive language as she described her experiences when she commenced working there:

*It was very challenging and fabulous, brilliant.* Mary (1, 12)

This confidence and affirmative attitude to her work seemed to have facilitated her transition from being student to becoming a labour ward midwife:

*I didn't find the transition that hard . . . I thought I'd find it worse . . . I just got on with it, it was sink or swim . . .* Mary (1, 34-36)

While listening to Mary I could recall my earlier interview with Amelia in Hospital A (p. 96). At that time Amelia, though four years qualified, still spoke about developing skills and confidence in aspects of practice including perineal suturing and strategies to support women in normal labour. In contrast Mary found the work in this new labour ward stimulating from the start:

*I suppose it was very autonomous, I felt that with the new building, it is one room and you have more autonomy than you would have had before because you have privacy and it is the relationship that you build up with the woman all day. So I loved that part of it, if everything goes according to plan there is a great sense of achievement.* Mary (1, 12-16)

The use of positive language was consistently used when midwives spoke of individual women or specific births. The sense of achievement the midwives experienced when a birth went well will be explored further in the next chapter.

The limited experience of junior midwives was not acknowledged. Edel, who was eighteen months qualified, stated that other midwives often assumed that she had more experience. She spoke confidently about her work and when asked about this stated:

*I suppose it was kind of forgotten, I suppose people kind of knew me from both places they presumed I was around for a lot longer. But I suppose they wouldn't see me as a junior midwife . . .* Edel (2, 32-34)

As a student, Edel had spent time in both Hospital A and Hospital B and was therefore known by many of the midwives. She transferred from Hospital B and, as with all the midwives I interviewed, missed the close working relationships that had previously existed among the staff:

*. . . it is just very big and impersonal (here) whereas before you kind of go, 'oh that's the woman you delivered and didn't she do great'. Whereas now it's like, 'what woman are you on? Your second lady already?' That is the only thing I have missed, somebody (midwife) might relieve you for breaks and you might never see them again (for the shift) . . . Edel (3, 1-6)*

I interviewed five midwives who were less than two years qualified and all spoke with confidence about their work. Sheila who started on the labour ward when the hospital opened spoke of her initial trepidation:

*. . . I was nervous and I was anxious, it had nearly been a year since I had worked in the labour ward, and that was as a student and I think when I moved initially the girls (midwives) from Hospital A thought I was from Hospital B and the girls from Hospital B thought I was in Hospital A. Sheila (1, 11-14)*

These midwives shared the same anxieties as the other midwives when the unit opened but they quickly gained confidence. As this early period was chaotic for all staff (see Chapter 10), the other midwives did not acknowledge the lack of experience of newly qualified midwives. Like Mary, Sheila coped well and spoke about her practice as follows:

*I suppose I am more confident, definitely, in what I am doing . . . the different regimes, say the high dependency unit you learn so much down there . . . and theatre . . . as students we would never really have done a huge amount in theatre . . . and there is the Induction Room as well. Sheila (2, 3-13)*

Within a short period of time, the junior midwives had adapted to the environment and gained confidence in all areas including the Obstetric Theatre, High Dependency Unit and Induction Room. As before, technical skills were important and being a

good team worker was also valued. As in my earlier interview with Amelia, junior midwives felt the need to be a useful member of staff. They did not want to rely on others for technical assistance and were prepared to become skilled to work in all areas as required.

These junior midwives coped well. When they spoke of caring for women in labour, they all spoke with assurance that they could deal with, and even enjoyed, the challenges of their work. Junior midwives seemed surprisingly confident. Their confidence may have emerged from their experience of working alone and having full responsibility for individual women in labour. This is an important finding and challenges the assumptions that midwives learn from each other and gain confidence with increasing experience (see Amelia p. 95). In this case midwives' learning had come directly from the woman themselves.

### **12.3 Cast on to the rocks**

While the midwives spoke about feeling isolated, the vulnerability that this caused was not mentioned directly but was apparent in the dialogue of junior staff. Edel spoke of how she felt entering a room and the responsibility that this brought:

*(You are) anonymous, you could go into the room and you could do anything in that room and . . . no one would ever know . . . Edel (2, 41-42)*

While Edel spoke confidently about her care of women in labour and provided some beautiful birth stories which will be described later, at the time of the interviews, there were over 80 midwives working in the unit, many who were newly employed, recently qualified or had little experience of labour ward work. That no one would know what was happening in any room was also reflected by Susan, who stated that:

*it is hard to know what goes on in the room next door . . . Susan (9, 21)*

Midwives were conscious of the activities on the labour ward corridor but stated that they were unaware of how other midwives practiced. The only time they worked together was when they assisted at a birth or relieved each other for breaks. When assisting at a birth, they did not remain in the room for long, as they would quickly return to their own woman who may have been left unattended.



The lack of support from midwifery managers was evident from many of the midwives and Meg described a scenario where she was assisting at a birth:

*I went in to assist and the woman had quite a large PPH, so we called the Reg(istrar) and it was all dealt with but just by the two of us. Whereas in the past . . . the person in charge would have been into that room straight away . . . to oversee this situation . . . They'd be aware of what is going on . . . (now managers are stocking and keeping things going, which are very important. . . . other midwives are very supportive and helpful.*

*Meg (7, 28-38)*

Midwifery managers could not always be relied on to provide support in emergency situations and this may have contributed to midwives becoming confident in managing these situations. Midwives relied on each other for clinical support. This was reiterated by Claire who informed me that:

*. . . (the midwifery managers have) so much else going on, ordering stores, phones ringing, secretary. They are so removed from the actual workings of the room . . .*

*Claire (4, 28-30)*

As mentioned previously, the midwives contacted doctors directly if they had any concerns. Sheila reported that if she was not reassured by the medical advice received, she could still not rely on the support of the manager on duty:

*I think it depends on who is on (duty) . . . if you come out and say, 'I am not sure about this' or 'I am not happy about this , (but) I have rung the doctors and they are kind of saying 'it is ok', (but) I am still not happy with it'. Some (midwifery managers) would kind of say, 'oh deal with it yourself' and others will come in and help you out.*

*Sheila (1, 32-35)*

Rose sought reassurance when she could and if there were any concerns, she:

*. . . always let the ward sister know the progress and she might suggest to you just to let the reg(istrar)<sup>39</sup> know as well . . . So the decision would come from the registrar.*

*Rose (13, 23-25)*

It was frequently mentioned that midwifery managers told midwives to contact the doctor directly rather than becoming directly involved themselves. In seeking assurance about aspects of care, Rose used what opportunities she could to check her practice with others:

*. . . I get more relaxed when I talk to more senior midwives because they go, 'Ah it's fine' . . . so then I kind of relax and say that is fine and relay that back when I go back into the room to the lady that everything is fine.*

*Rose (13, 28-31)*

Rose was reassured when she had the opportunity to share her concerns with another midwife. This impacted directly on her care as the reassurance she felt was conveyed directly back to the woman in labour.

In contrast, Mary had no concerns about consulting doctors directly. This was reflected by her early experiences:

*I suppose when I started first I would have been 'bleeping'<sup>40</sup> the doctor about everything, I was a small bit nervous, whereas now (I) kind of know (what to do).*

*Mary (2, 2-4)*

The term 'sink or swim' was repeated by Mary, and while she contradicted herself about the amount of support she received, her confidence belied any vulnerability:

*I'd say maybe I didn't feel I got an awful lot of support but then maybe I didn't need it, I suppose I was happy enough, I suppose it was kind of sink or swim, so yes, that would be it.*

*Mary (2, 14-16)*

Where previously midwives worked closely with each other, now there were few opportunities to observe and learn from others. As Mary stated:

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<sup>39</sup> A registrar is a medical practitioner (Non-consultant hospital doctor) undergoing specialist training. In this situation the midwife is referring to an obstetric registrar who will make clinical decisions about women when required.

<sup>40</sup> Hospital system for alerting a doctor on call using a portable pager, referred to as a 'bleep'.

*To be honest with you I haven't relieved an awful lot of breaks because I am always with someone (in labour) . . . (and) I actually haven't assisted with an awful lot of others . . . that is one thing I haven't done. Mary (9, 22-30)*

She relied on learning from her own experience and was now more assured in the decisions that she made:

*I find after six months now my experience . . . I am feeling more confident and I know those (women) that will do well and I know those that will be slow and you do learn a lot. You learn to trust yourself a bit more as well Mary (5, 5-8)*

This confidence had emerged from caring from women in labour largely without the support of other midwives or having the opportunity to observe their practice. Self-reliance was evident in the dialogue of all the junior midwives and when I asked Mary how she developed her confidence she stated that:

*I'd be the type that would engage in a lot of reflective practice that after every delivery you would kind of think about what happened for that and you do learn from that Mary (2, 4-6)*

She went on to inform me about some things that she had learnt:

*Well IUGRs,<sup>41</sup> I have really noticed that if ever I have an induction and it is an IUGR and they are going on Synt(ocinon), I am afraid straight away because the babies just don't like Syntocinon at all . . . you have to be very, very careful . . . (it) can cause a bit of difficulty. Synto(ocinon) is the main thing that I have learned . . . things can go wrong very quickly with it and you have to be very careful with it. Mary (2, 25-34)*

While Mary did not admit to errors of judgment on her part, she had learnt not to be complacent with women at risk of complications. The use of oxytocin (Syntocinon) may cause fetal heart decelerations which can lead to an emergency caesarean section being required.

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<sup>41</sup> Intra uterine growth restriction (IUGR) refers to a fetus who has not grown at the expected rate for his/her gestational age. Labour induction may be undertaken if there are concerns about fetal wellbeing.

Mary was also developing skills to support women experiencing a normal birth:

*. . . if you have women coming in, in spontaneous labour you could practice what you were taught in class about the all fours position, pain relief, the birthing ball, the shower.*  
Mary (1, 21-23)

Without the opportunity to work closely with other midwives or to discuss aspects of care, Mary relied on learning from the women themselves:

*And another thing I have learned is that every woman is different . . . how would I say it now, you would just have to reflect on every birth and you can learn a lot from your experience.*  
Mary (3, 3-5)

In contrast to the midwives interviewed previously, none of the midwives interviewed this time spoke of learning from other midwives. When I asked a senior midwife about opportunities to see how others practiced, I was informed that there were few opportunities for this:

*It's hard to know simply because I only know what I am doing myself.*  
Susan (4, 37)

The vulnerability of some newly qualified midwives was reflected by others, Sandy acknowledged that:

*It is quite scary for them being in this place because it is so big and you are sent into this room which is like an island.*  
Sandy (11, 31-33)

Claire was also concerned about the lack of support available and considered that some midwives summoned a doctor too quickly (see Mary p.145):

*. . . yesterday a midwife, not long qualified had a (CTG) trace where there was huge accelerations<sup>42</sup>, it was beautiful, it was text book stuff, the base line was 140 but she had massive accelerations, you could see the foetal movement profile, beautiful. She (the midwife) called the reg(istrar), . . . he was talking about FBS<sup>43</sup> . . . and she came out to the CMM, who was in a bit*

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<sup>42</sup> Acceleration refers to an increase of the fetal heart above the base line rate.

<sup>43</sup> Fetal blood sampling (FBS) is a procedure where a sample of blood is obtained from the fetal scalp to determine the pH of the blood. Depending on the result a caesarean section may be indicated.

*of a flap because she had so much else going on . . . I just go in and have a look at that trace . . .and I had to literally explain to this midwife . . . I said to her, 'that is a beautiful trace, don't let anybody convince you otherwise'. . . (the doctor) just walked out the door . . .* Claire (4, 23-45)

Because of Claire's intervention, this woman avoided an unnecessary procedure when a CTG recording was misinterpreted. The concerns that the senior midwives raised about the lack of support for junior midwives often concerned CTG interpretation. Whether these senior midwives were more risk adverse because of their own experiences or whether it was related to the high risk women in the unit, including women undergoing labour induction, was not clear. However, it was not just junior midwives who did not have opportunities to discuss aspects of care. Senior midwives also missed out on this, and the appearance of a second midwife joining them for a birth could be a welcome sight:

*. . . if you had a delivery that you might have some slight concern in your head, when you see another midwife coming in (to the room) it is great, you know there is someone there. And I think the junior midwives would probably feel that once they had somebody or someone else there, just even to ask the question or whatever* Susan (5, 13-17)

When I had interviewed the midwives in Hospital A, one of the problems that they voiced was the potential for doctors or other midwives to interfere with their care. A positive aspect of this was that, a midwife or doctor was readily available to discuss any concerns. Thus decision making could be shared. All midwives in this new unit valued their independence but they also missed the close working relationships with their colleagues. Senior midwives raised particular concerns that juniors were not supported. In contrast, as the next theme indicated, this did not seem to be an overt concern for the junior midwives themselves.

#### **12.4 Your own lady in your own four walls**

The midwives valued the autonomy that they now experienced and unlike the previous interviews, the language that the midwives used in relation to women in labour had altered:

*I suppose it is very autonomous . . . because you have the one room privacy and it is the relationship that you build up with the woman all day. So I love that part of it . . .*

*Mary (1, 12-23)*

As mentioned previously and will be seen further in the next chapter, the words midwives used were much more positive and indicated a different experience.

In contrast to the activity outside the labour room, here a paradox was apparent in the dialogue of the midwives. Within the individual rooms of this large maternity unit, midwives experienced less surveillance than in their previous hospitals. They thus experienced greater freedom in their work. Midwives had previously felt that 'midwifery' was not valued; in this new setting the midwives seemed to have strengthened their identity:

*. . . it's the same work but I think you have got a bit more autonomy here actually, when you go into the room and you are the midwife there . . .*

*Amelia (3, 30-33)*

The midwives in Hospital A had been almost interchangeable, with the possibility of doctors or other midwives intervening and making decisions about care. The size of the new unit had brought about a change in the way all staff worked. Doctors focused their attention on women having their labour induced or experiencing complications, and midwifery managers were busy managing the unit. This left the midwife alone, particularly with those women whose labour seemed to be unproblematic. The midwife was trusted to provide appropriate and safe care:

*once there is any intervention . . . they (doctors) pop in and out whereas if you have someone . . . in spontaneous labour . . . they don't see that as a problem*

*Ann (8; 8-11)*

Susan, who had frequently been in charge of the labour ward in Hospital A, enjoyed providing more direct care:

*you have your own lady you look after in your own four walls . . . and unless I feel that I have a problem . . . I am quite happy to relate to the woman and work to whatever her requirements are, her needs or her wants are . . . I*

*suppose it is a slightly different scenario in Hospital A . . . The one to one is fine by me, absolutely; I have no problem with that.* Susan (7, 3-15)

Midwives enjoyed their autonomy and, as mentioned before, if there were no particular concerns, they used affirmative language when they spoke of caring for women in labour. Midwives from Hospital A, were particularly positive about this aspect of their work. Lucy expressed the heightened sense of responsibility that came with this autonomy:

*. . . you have to make up your own mind on how you are going to do it. But to me that is good because it is keeping to your professionalism, your accountability and making you think and making you aware of 'how am I going to account for this woman's care' . . .* Lucy (3, 30-34)

The privacy was valued by all. Midwives from Hospital B, who expressed greater regrets, than Hospital A midwives, at leaving their old unit, also used positive words when they described their experiences in the room. This was expressed by Claire as:

*You are cocooned in some ways . . . it is good, the doors do close, (there is) a curtain just inside the door . . . and people a lot of the time respect it.* Claire (4, 11-14)

Amelia, who previously spoke about the technocratic skills required by labour ward midwives, now informed me how this freedom from surveillance enabled her to use various strategies to support women, without anticipating the censure she had previously experienced:

*I find that you are able to conduct your midwifery care very well . . . if you want to do intermittent monitoring or if they want to mobilise and they have their birthing balls or Pilates balls and what have you, you can just do that if you are happy. But sometimes in Hospital A, I remember X (a midwife in charge) making a comment . . . 'to do a trace (CTG) every hour' but there is no point in doing a trace every hour if you are doing intermittent (monitoring) . . . it is great for those women who go into labour naturally . . . because they can do whatever they want, they can go on all-fours or 'on the*

*ground' or whatever they want . . . It actually leads to better deliveries.*

*Amelia (3, 16-28)*

In Hospital A, the birthing balls had not been used and when I had interviewed Amelia there, she told me that discontinuing a CTG invited adverse comments from midwifery managers. Now, there was no one to oversee activities and midwives had the confidence to implement their own decisions about care.

This lack of surveillance and acceptance of responsibility had facilitated junior midwives to gain confidence and Claire informed me that sometimes, even junior midwives now encouraged doctors not to interfere:

*(Doctors) sometimes think they need to be in on everything and really a lot of the junior midwives realise that the doctors don't need to be in on a lot of these situations.*

*Claire (4, 15-20)*

This will be explored further in the next chapter. Midwives had more confidence in articulating their views and this was now considered acceptable:

*The midwives themselves have a bit more say. It is good yes. Susan (2, 28)*

The old structures where a midwifery manager or doctor could oversee and influence the practices of labour ward midwives no longer occurred. As will be seen, this gave midwives confidence to incorporate new practices.

## **Conclusion**

This chapter has explored the midwives experiences of working within the individual labour rooms. The title of this chapter, 'Any port in the Storm' reflects the midwives' new freedom and potential vulnerability as they entered individual labour rooms to take responsibility for a woman's care. The subthemes are, 'island in the storm', 'sink or swim', 'cast up on the rocks' and 'your own lady in your own four walls' which also reflected a new autonomy. This new setting was larger and had greater throughput of women than previously experienced by any of the midwives. The size of the unit meant that doctors and senior midwives were caught up in the workload and were not involved in individual women unless a problem was identified. The midwives no longer had opportunities to discuss aspects of care with



their colleagues and would be told to contact a doctor directly if they had any concerns. There was an assumption that assistance was always available but on occasion this did not occur. A junior midwife described this as '*to sink or swim*'.

Though all midwives felt isolated in the room they did not admit to feeling vulnerable and even junior midwives rose to the challenge of the setting and reported positively on their experience. As will be explored further in the next chapter, the confidence the midwives expressed in the very positive language that they used such as being '*cocooned*' in the room, reflected a new experience. The isolation had led to increased autonomy, decisions were no longer challenged and no one interfered with their care. As will be seen in the next chapter, when a birth went well, the midwives gained confidence from the women themselves. Judgements about the care they provided was reflected back to the midwives by the feedback they received from the women.

Autonomy is not usually associated with midwives working in an obstetric led unit and was not a feature of the midwives experience prior to the move. How this impacted on the midwives' practice will be explored in the next chapter.

## CHAPTER 13 IN THE EYE OF THE STORM (MIDWIVES' TERRITORY)

### Introduction

As was discussed in the last chapter, this small labour room, full of equipment and supplies had become the midwife's field of work. If all was straightforward in a woman's labour, the midwife had full responsibility for the woman's care unless assistance was sought. As Susan stated, *'you have your own lady to look after in your own four walls'* (p. 149). As will be explored in this chapter, this escape from the surveillance and potential for interference enabled nascent midwifery practises to emerge and, as a consequence this chapter is titled 'In the Eye of the Storm'.

As the midwives spoke about their work, the room where this work was enacted had become the midwife's 'territory'. Once they entered this space and took responsibility for the woman, they also took control of the environment and managed care, taking the individual woman's needs into consideration, but also reflecting their own beliefs about what can be achieved at a birth. As will be seen, midwives often negotiated a plan of care for the woman and supported her through labour in order to achieve, what they considered, to be an optimal birth. Thus, the sub themes explored in this chapter emerged as; 'time and place - my space my territory', 'forming bonds', 'steering a course- the epidural question again', 'spending time, wasting time – a basket of strategies', 'breaking free', 'protecting the space', 'getting into the psyche', and 'labouring in the eye of the storm – sharing the beauty of birth'.

### 13.1 Time and place - my space, my territory

Moving into a large maternity unit led to changes in the midwives' experience of caring for women in labour. When a midwife entered a room, the inner space had become her 'territory' and as Sandy described; *'when you put on the 'In Use' sign, it is yours'* (5, 18). At the time of the interviews, the midwives were by now familiar with their environment and could spend several hours with a woman in labour. Within this context, in certain respects, both time and space were under the midwife's control.

Barbara spoke about her experience of this labour time:

*I know somebody . . . and he says, 'how do you work in a room . . . you might be with the same woman all day long and you may never leave that room, how do you do it, how do you physically do that?' . . . (I respond) 'patience'. I suppose I accept that it is 'time'; you have to accept that that is the norm.*

*Barbara (13, 33-39)*

Once a woman was making progress, there was no concern about the length of labour. Barbara enjoyed this aspect of her work and this characteristic of labour time was contrasted by another midwife. Elaine had been a student midwife in Holles St where Active Management of the Labour<sup>44</sup> was the protocol for care:

*. . . the minute they came into the labour ward their first examination (VE) . . . 12 hours from that stage was when they had to have had their baby. Whereas here . . . (a woman was) in labour since 2 o'clock, being induced . . . She was here for over 17 or 18 hours . . . I couldn't get over it. . . But in Holles St it was 12 hours and they would have made their decision at that stage.*

*Elaine (10, 24-37)*

Elaine's need to adjust her thinking to the concept that 'labour takes time' in this large and busy labour ward, was a difficulty for her.

This relaxation over the duration of labour had an impact on the midwives' practises. This was apparent from a discussion on the second stage of labour which was reported to me. Ann stated that there was not always agreement on how long this should take:

*. . . one of the midwives had three normal deliveries without epidural and the manager said, 'Oh I don't know, these women, I have a big thing about long second stages and poor outcomes for the baby' and that particular midwife said, 'Well if that is what you are saying I would have had three instrumental births'*

*Ann (11, 35-40)*

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<sup>44</sup> The protocol for Active Management of Labour includes that labour is confirmed following a vaginal examination by a senior midwife. Amniotomy is routinely performed and a commitment made that the birth will be complete within 12 hours

Midwives could express their different views about labour time and, unlike the earlier interviews, a diversity of approaches was now possible. As others were not involved in a woman's care, it was up to the midwife to decide if the woman would need assistance. A doctor would be called and an instrumental birth would be likely. Midwives now had discretion and for those midwives who believed in 'normal' birth, the birth could now be awaited. Strategies midwives used to effect vaginal births will be explored later.

In relation to the labour room, there were just marginal adjustments that midwives could make to minimise the impact of the clinical aspects. Some spoke about trying to create a pleasant ambiance; this was described by Rose as:

*keep it quiet and calm and the music . . . pull the blinds, dim the lights and you have got a lovely setting straight away . . .*                      *Rose (3, 16-21)*

The language midwives used in describing this space for labour and birth was always positive.

Lucy tried to create a space where women could feel safe and utilise the space according to their own instincts:

*I don't take any notice of the room, or bed it is just whatever way the woman is . . . just whatever way that she comes in and uses the room . . . I don't change it around . . . I would be conscious of not having the lights blaring and the curtain is over the window . . . asking her does she want music. . .*  
*Lucy (4, 19-33)*

Lucy provided some examples of women making use of the room according to their own needs which will be detailed later.

In contrast to the earlier interviews in Hospital A, midwives spoke of time and space in new ways. Labour was not rushed and there was an acceptance that this took time. Midwives spoke of creating a 'lovely' space, whereas, mentioned previously, women could be 'cocooned' (p. 150). The midwives were agents in making this time and space for birth and a diversity of approaches were now accepted.

### 13.2 Forming and strengthening bonds

In order to create a positive environment for birth, when they first encountered each other, the midwives had to establish relationships with women they had not met before. For the midwife this was important so that the woman could relax and feel secure. Completing the required paperwork could be a useful method to establish a rapport. Edel maintained that this helped her to get to know the woman and encourage her to relax:

*I'll palpate her and I'll say 'Listen I'll put you on a monitor and do you want to sit on the bed, but I need to do a 20 minute tracing, and I have all this paperwork, I have to do it . . .' by doing that we chat and I ask how her pregnancy was . . . you have all that done and you get an idea of what is happening . . . and once you get to know them both I often say to the husband, 'Do you want to go for a cup of tea or coffee . . . or do you need to move your car?' . . . the woman often opens up a bit more when she is on her own, just relaxes and gets to know you . . . I suppose when you are with the woman you can get an idea of what her pains are doing and . . . what is happening . . .*

*Edel (11, 21-40; 12, 1-14)*

While being engaged in these various activities, Edel assessed the woman's ability to cope with her labour and made judgements about her progress towards the birth. As will be seen, it was not just that the woman could relax that was important, midwives wanted to establish a reciprocal relationship with the woman which involved mutual trust.

Once a relationship was established, the bond could strengthen but while the midwife remained largely in control, it was noticeable that they now negotiated any strategies or procedures they wished to undertake. During the previous interviews, women had seemed largely passive in the discourse of the midwives; now there appeared to be a partnership in care. As Susan identified, reciprocity and trust were an important consideration:

*. . . I take each case as it comes, get a rapport with the lady and her partner or husband and find out what her concerns or needs or wants will be at a very early stage and then work with it. And then, bit by bit, as you feel . . .*

*whatever (procedures that) might be necessary for her to progress, she has a better understanding and a better trust of you. I think that is very important because 'you have to have this, this, this and this', and ok, you know it is best for her but I like to be very diplomatic, you have to be. I wouldn't like someone saying, 'oh that is fine'. I know you are the midwife, you are the boss, or you are in charge of the case but you like to give her some of the power which she is quite entitled to have with regards what her care will be.*

*Susan (6, 38-39; 7, 1-10)*

Some midwives remained more controlling and for Susan, establishing trust with the woman was in order that she would accept various procedures and interventions as required. Yet though compliance was expected, passivity was not valued and Susan wished the woman to become involved in the decisions being made. This can be contrasted with how the midwives in Hospital A had talked about the cascade of interventions which had seemed almost inevitable in that unit. Women in Hospital A may have been consulted, but this did not emerge as important at the time. In the dialogue of the midwives, women were portrayed as being passive.

It was not always easy to for midwives to establish rapport, particularly if labour was advanced and the woman was distressed. In this situation the midwife took control:

*. . . she wasn't coping at all well so I had to get quite cross, well not cross but I had to get quite stern with her and say, 'Put that into your mouth (Entonox) and use it,' and she thanked me after, but she (had) wanted everything natural but she wasn't coping. Sometimes you have to just say, 'That is it now, do it,' but not forcing anyone, but she used it (Entonox) and she flew it (and progressed quickly) after that.*

*Edel (10, 21-26)*

Edel felt that she had supported this woman through a difficult time by being firm. She justified this on the basis of being aware of the woman's plans for the birth. As discussed in the last chapter, it is possible that another midwife might have suggested an epidural at this stage. Edel went on to describe this as a positive birth for which the woman was grateful and thanked her, but it must be noted that midwives did not often relate stories that reflected badly on their practice.

Midwives were aware that this newly formed relationship was tenuous and could easily be lost if they spent time away from a woman, even for a meal break. This was articulated by Ann:

*. . . sometimes that break in continuity . . . a woman has (had) trust in you . . . and then you are gone and you feel they lose it a little bit . . . Ann (3, 8-10)*

When trust was lost, reciprocity could not be maintained and this was viewed negatively by the midwives. Trust and reciprocity was important for the midwives as it seemed that this led them to have an emotional investment in the birth. The relationship was thus important for the midwife's experience of the labour and birth. As will be seen later, once this was established the midwife became protective of the woman and an advocate for her needs. This contributed to midwives having 'good births' and 'good days' at work.

### **13.3 Steering a course- the epidural question again**

In Chapter 11, the issue of epidurals was raised because midwives repeatedly mentioned that some women had an expectation that an epidural would be readily available whenever requested. Schytt (2010) reported that the decision to use an epidural during labour is influenced not only by individual woman but also by the cultural practice in the labour ward. While the culture in this unit was to provide women with epidurals on request, there were many midwives who tried to dissuade women from requesting one. Midwives recognised that women varied in their expectations for pain relief but as Barbara stated, '*nothing is cast in stone*' (4, 4). Midwives associated epidurals with instrumental births and they all stated that they preferred caring for women without one. It was interesting that Patricia described this as '*real midwifery*' (see Chapter 4):

*I'll take the woman without the epidural because that is the kind of care I'd like to give . . . because it is 'real midwifery', if there was a choice. . . .*  
*Patricia (7, 31-33)*

Midwives could not choose which woman they would be allocated to care for, but all stated that they tried to avoid, or at least delay, a request for an epidural' if they perceived that a woman was coping well.

*And if I think she is doing very well and she is using that gas (Entonox) so, why is she talking about epidural, 'I will give you some pethidine for a while and see how you go, you can have your epidural at any stage'. Edel (10, 12-15)*

Both distraction and negotiation were often mentioned:

*. . . if they are kind of 3 or 4cms or more and they really want an epidural then just say, 'Fair enough and this is what the epidural entails now unfortunately you are going to need to stay in the bed and have your drip and catheter and all this', and they say, 'Yes fine, I want to have it . . . is it a good idea?' And you say, 'These are the alternatives'. . . Sandy (10, 10-15)*

Midwives used Entonox and pethidine, in combination with mobilisation or other strategies, in anticipation that labour would advance before an epidural was required:

*She was . . . on the birthing ball and she was using Entonox and she was getting quite distressed, considering an epidural. And I suggested, did she know about pethidine and she said she'd give that a go . . . Rose (6, 6-10)*

Midwives relied on her relationship with the woman, so that as labour progressed options could be discussed:

*I always say to them, 'look I'll get you through this, but will you be sorry you didn't have an epidural, I know it is very hard to gauge that now but if I can get you through this will you be glad you didn't have an epidural'. 'Yes?' What the (women) want to know is that you are going to be there with them the whole way . . . And then they'll say, 'ok'. They get to 6cms (dilated) which is the crucial time for the epidural; (women) are always looking for it then. And they say, 'I think I want it now'. And I say, 'you were unsure about it earlier on, I can get you through this', we have built up a bit of rapport at this stage so 'if I get you through this, will you be glad? I won't leave you; you are doing so well, you have done all the hard work'. And they go, 'yes I think I could'. And then they might roar it out then, they might just lose it for a certain length. I always check back with them afterwards . . . and say, 'are you glad now, and you must be honest with me'. And they say, 'I am delighted that I got through it without it, but I couldn't have done it without you'. Claire (13, 2-18)*



Claire wanted the woman to value the support she was providing and also checks that the right decision was made, but it must be noted, the woman was unlikely to say anything negative about this at the time. In contrast to the previous interviews, it was now important for the midwife to collaborate with the woman and so that she would endorse any decisions that were been made. Compliance was not valued. For the midwife, the goal was an optimal birth for the woman, but, as will be seen, this could only be judged to have been achieved, if the woman appeared to be pleased with the birth and the care provided.

Apart from using pethidine and Entonox, alternative options for pain relief were offered but the midwives had to be careful if it could be perceived that they were dissuading a woman from an epidural:

*. . . you don't want to be seen to be talking them out of it. But they have this in their head, 'I am in pain so I need it, I need it now', some are actually coping really well . . . But I say, 'right you let me know what you want, the epidural is there if you need it but I am not going to keep saying to you if you want it, if you change your mind you just let me know'. Sheila (2, 19-28)*

There was a sense of achievement for both the midwife and the woman if the woman had a normal birth without an epidural, as Ann stated:

*I think the majority (of women) do feel a sense of achievement themselves that they have, done it (given birth) without an epidural. Ann (10, 30-31)*

Midwives were also aware that complaints had been received when women did not get the epidural that they had planned for their labour.

A number of midwives deliberately avoided mentioning an epidural as an option for pain relief. As Lucy explained:

*I made a very conscious decision that I wasn't going to offer an epidural as an alternative (to experiencing the pain of labour); I just wasn't going to physically do that often. If the woman requested it, it is not any hassle  
Lucy (4, 13-15)*

She went on to describe the choice of an epidural as indicating the woman was opting out from the experience of the birth. Like the other midwives, Lucy used a range of distraction techniques:

*. . . I just knew that her next thing was she was going to ask me for was an epidural and rather than her asking me for an epidural I distract them . . . that really works for me.*  
*Lucy (10, 15-21)*

Though caring for women in labour without an epidural could be considered as ‘*real midwifery*’, the midwives acknowledged that it took more effort to support these women. As Barbara stated:

*Women who . . . are quite distressed you have to work really hard to bring them on board and to get a feel of what their expectation of their labour is. I could have my expectations of what I would like for them but... you have to use all your skills to support her, to keep her going because there are points where they have had enough and say ‘I want an epidural’. And I guess you use things like distraction that is a huge factor for me and trying to negotiate with them.*  
*Barbara (3, 35-38; 4, 1-6)*

While midwives used opportunities to dissuade women from an epidural, they also had to judge whether this would be the correct decision. They did not always get this right. Barbara related one story where she felt that she had let the woman down as she subsequently required a forceps for the birth. She contrasted this outcome with that of another woman who she had cared for earlier in the day:

*I just think she was disappointed she hadn't had her epidural. So how would I handle things differently? I don't know, I would feel that herself and the previous lady in the morning were the exact same but the outcome was different for both of them.*  
*Barbara (8, 7-11)*

The unpredictability of a birth was difficult for midwives who discouraged epidural use. In this scenario, an epidural may have resulted in an easier birth and a more positive experience for the woman.

It must also be noted that, unlike the experience of the midwives interviewed in

Hospital A, in the new unit, anaesthetists no longer entered the room to offer women epidurals. Doctors and other midwives did not interfere with a midwife's care.

### **13.4 Spending time and wasting time - a basket of strategies**

As there was no pressure to deliver quickly, a variety of strategies were required to help women to cope with their contractions, particularly if an epidural was to be avoided. In contrast to Hospital A, the midwives had a greater range of strategies that they could offer. Space in the room was limited but the use of mobilisation, the birthing ball and the shower were useful strategies. This was a positive aspect of working in the new unit:

*. . . the rooms are great, you can have a shower or you can move around that area whereas we didn't have that freedom before . . . Amelia (7, 1-3)*

Though activity was encouraged, this was always confined to the room:

*I try to keep them busy, if they don't come down and say, 'I want an epidural' that is perfect, I never mention that to them . . . I get them into different positions, get them to go for a shower . . . it is all about steps and not thinking (that the birth) is going to be soon, just about spending time and wasting time. I find I do something different every so often, 'we'll do this now', so that the time won't be long . . . Edel (4, 30-36)*

Like Lucy, Edel was another midwife who avoided offering or mentioning an epidural.

The large birthing ball and use of the shower had become popular:

*. . . bring the ball in the shower, the shower can be great . . . I'd let them on (the ball) with the Entonox for a while and then they might go through a transition phase<sup>45</sup> and then I'd say maybe the shower, it is different with every woman really. They do find the shower great, it can be great.*

*Mary (7, 42-43; 8, 1-3)*

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<sup>45</sup> Period when a woman is approaching the second stage of labour, the nature of the changing sensations some woman experiences at this time can be distressing.

In Hospital A, a shower had not been available and mobilisation was restricted by the shared space. The frequent mention of the ball was interesting. These had been available in Hospital A and Hospital B but were rarely used. Claire now encouraged their use and made a point of this to the medical team:

*. . . I try to be sure to be seen going down the corridor with the ball. 'And, oh where are you going with the ball?' (I) try to just get it more in vogue. I mean initially we used to be all laughing at the ball, I laughed at it myself when I used to see women in Hospital B coming down the corridor with the ball, 'I say, oh the ball is coming in' . . . but now I make sure the consultants see their private women sitting on the ball. Like one of the professors comes in and, 'oh she is on the ball?' And 'yes Prof, she is on the ball'. 'Right'. They don't know what to say or do.*

*Claire (16, 3-12)*

The balls now had a widespread acceptance and were popular with many midwives. Susan, a Hospital A midwife, also commented on the greater use of the balls:

*. . . (They were around previously) for a short while but it didn't last too long (laughter) and here now . . . (they are) great, I must say if a woman wants (to use one) or women who could be encouraged that this would be great for her. . . it is very good . . . they find it very comfortable. Moving around (on it), bouncing a little bit.*

*Susan (3, 19-29)*

Midwives who expressed preferences for the ball did not restrict their use to women in spontaneous labour:

*. . . (I) sit them on the ball and put them on the (CTG) monitor . . . it depends on the woman you see, it depends on their whole psyche . . . the ball can be very effective. We had one lady who sat on the ball for the whole night and she had her Syntocinon and she got to 'fully' (dilated) and she needed no epidural . . . but she did it. So the ball can be very helpful*

*Mary (5, 34-41)*

Previously women whose labour was being induced were confined to bed. This was because of the need for continuous monitoring and an I/V infusion. Now the ball was also being used for these women:

*the only thing you can provide for her as a change from the bed is the gym ball, you sit her out on the gym ball and she is on continuous monitoring and she is on the ball and on Syntocinon drip . . . they try them for a while anyway . . . she is limited to where she can go and the ball is literally at the side of the bed but it is as a change from the bed that you'd introduce it to her anyway*

*Rose (4, 1-9)*

As with the approach to epidurals, the adoption of both the ball and shower varied among midwives. Elaine mentioned the strategies she used:

*I just shove everyone into the shower and bring in the birthing ball into the shower and people sit on the ball and shower and just spend the majority of the time there if they are willing to go for a shower. I suppose birthing balls walking, TENS<sup>46</sup>, aromatherapy and if they have done reflexology and things like that if they wanted to go through all of those*

*Elaine (2, 20-30)*

Unlike the epidural, these strategies did not require medical involvement. This appeared to have strengthened midwives' professional identity, highlighting midwifery skills in contrast to those of the medical team.

Midwives tried out different techniques, as Barbara stated:

*I guess I would always say . . . what you see that actually works well, that is good practice. Then you have to gather that up, it is like putting it in a basket. That is what I like to do.*

*Barbara (2, 33-36)*

The basket of strategies midwives used to support women through labour was with the purpose of 'spending time and wasting time' while labour progressed, or to delay or avoid requests for an epidural. Midwives varied in the strategies they selected and as indicated in the last chapter, they were unaware of what other midwives did. They adopted practices for themselves according to their perception of what worked best for women. These would be negotiated and tried out. If one did not work, another could be selected; time would move on and labour progress. An epidural which may

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<sup>46</sup> Transelectrical nerve stimulation (TENS) Electrical impulses are transmitted to the back via electrodes. This activates nerves which do not transmit pain and interferes with signals from pain fibres. TENS inhibits the person's perception of pain.

have been originally planned might not be required.

For the women in labour, a bath was available at the end of the corridor, but few midwives mentioned it. Several stated that they forgot that the bath was there. For all strategies, both the women and the midwives stayed inside the room. Midwives did not leave women alone and returned quickly from their breaks.

A range of strategies was also used for the second stage of labour. These included encouraging women to change position for the birth:

*I encourage changing positions . . . leaning up over the back of the bed, you'll find a lot of the OPs<sup>47</sup> have back pain, and just to lean over the back of the bed it seems to help the baby's head to rotate.* Ann (2, 5-8)

Leaning over the back of the bed was facilitated by the new beds which could be adapted for different positions:

*The way you can pull that down and get them to sit at the end, with the bar is brilliant for kneeling over the back . . .* Edel (5, 10-11)

Mary had recently begun to use this as an alternative position for birth:

*I have had about four deliveries now with the 'all-fours' . . . I had only seen one in my training, but it is lovely . . . So it is a fabulous position to give birth in . . . just get them to 'full dilation' beautifully but as soon as they get to 'full dilation' and they turn it is just lovely.* Mary (8, 31-33)

Amelia spoke of positions either on or off the bed in order to help women find what was right for them:

*. . . for 'all-fours' you can flatten it (the bed), somebody could be on the ground as well on 'all-fours' or whatever. And the kneeling then you can raise the head of the bed and...* Amelia (12, 18-19)

While midwives in Hospital A occasionally used different positions for birth, this

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<sup>47</sup> OP refers to occipitoposterior, a posterior position of the fetal head in relation to the woman's pelvis. As the diameters of the fetal head are larger in this position it is not considered optimal for birth.

was very infrequent (p. 90). It was interesting that in this unit the midwives frequently spoke of using particular midwifery techniques to support women in labour. These were not so apparent in the earlier interviews.

### 13.5 Breaking free

While following unit protocols, midwives had discretion over certain aspects of care and there were examples of midwives breaking away from the conventions that had previously been the norm. There were many stories of midwives seeking to normalise birth and even ignoring hospital policies if warranted. An example of this was in relation to vaginal examinations. The policy in the hospital was that vaginal examinations should be performed every four hours or as otherwise indicated. Because there was no one overseeing them, midwives used their discretion in how often these were performed. Several avoided them where they could and as Barbara said:

*. . . isn't it wonderful not to diagnose somebody fully (dilated) from a VE (vaginal examination), you diagnose them . . . when you see the vertex on the perineum,<sup>48</sup> that is lovely.* *Barbara (7, 24-26)*

As mentioned earlier, the language midwives used to speak of births was interesting. In contrast to their dialogue of their general experience of the workload in the unit (Chapter 11), when midwives spoke of their experiences of caring for individual women in the isolation of the labour rooms, the positive words that they used reflected a different reality. This is in contrast to the language used by the midwives interviewed in Phase I.

Edel was another midwife who avoided vaginal examinations. She drew on intuition and other non-standard signs of progress to guide her:

*I try not to examine them . . . you know yourself by looking at them (the women) what they are doing. Maybe at the end if they are coming near the*

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<sup>48</sup> The second stage of labour is defined as the period between full cervical dilatation (10 cms) and the birth of the baby. Full dilatation is confirmed by vaginal examination. The second stage of labour can be up to three hours or may be considerably shorter.

*end of their tether I sometimes watch their 'purple line'<sup>49</sup> just to see, I find that very good . . .*  
Edel (4, 36-39)

Edel also made her own decisions about examinations for women whose labour was being induced:

*'They' would say every two hours with Synt(ocinon) . . . but I don't do it, I just leave them and watch them . . . I don't examine women that often. I examine them maybe when I'd start Synt(ocinon) and I'd wait until they are contracting well.*  
Edel (13, 27-30)

Midwifery intuition had been apparent in midwives in Hospital A (Marie and Margaret) but now the midwives had autonomy in the decisions that they made. The 'they' that Edel is referring to are 'other midwives'. These other midwives' did not determine or monitor Edel's practice. This account could be contrasted with Sarah's experience as recounted earlier (p. 86). A diversity of approaches was now possible (see midwives who have a 'problem with long second stages' p. 154). In the absence of surveillance, midwives were autonomous and could choose which practices and policies to enact.

Labour was managed according to the midwife's preferences and took account of the woman's plans for the birth. Unlike the earlier interviews where inference was probable, now midwives could practice in accordance with their own perception of best care.

The midwives interviewed, all claimed to normalise births and spoke of very positive birth experiences but both Barbara and Lucy maintained that they were recognised by their colleagues as 'normal birth midwives' and expressed this directly:

*. . . a woman . . . 'doing her own thing' and whoever (midwife) was in charge looked at me and said, 'you go into her so will you?' So I said, 'yes fine thank you' and off I go. So I knew that the (midwife) perceived me to be somebody who had no problem being with somebody who wanted 'to do their own thing', perfect that is brilliant.*  
Barbara (7, 11-15)

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<sup>49</sup> A purple line that extends from the anal margin through the cleft of the buttocks as labour progresses possibly caused by pressure of the fetal head on maternal blood vessels supplying this area. It may reflect cervical dilatation.



It still seemed that women who wished to give birth without intervention were perceived to be the exception. Lucy was also recognised as a midwife who supported a natural birth and she related how a senior midwife commented to a woman in labour:

*'oh you are all right here because you are with Miss Normal Birth' . . .  
acknowledging that that is what I would be supporting . . . Lucy (3, 33-36)*

While the remaining midwives indicated a preference for caring for women in spontaneous labour and achieving a normal birth they also stated that they did not mind which 'type' of woman they looked after. As will be seen later, several of these midwives also actively sought to normalise birth, and preferred providing '*real midwifery*', but unlike Lucy and Barbara, they did not identify themselves as 'normal birth midwives'.

### **13.6 Protecting the space**

As stated earlier, it was important for the midwives to establish a reciprocal relationship with the woman. Midwives were aware of what the woman wanted for her labour and birth and, tried to ensure that she had an optimal experience. A new element in their dialogue was that they were now protective of women in labour and felt that they had become their advocates. In Hospital A, because of the shared labour rooms, privacy had been difficult to maintain. Claire was just one of a few who expressed what now happened:

*Sometimes people just walk in but a lot of the time people respect it and they say, 'hi, what is going on in there? The doctor is doing a 'round' can we come in?' And quite boldly I'd say, 'in the middle of an examination here, I'll fill you in, in a minute'. Or 'we are in the middle of a normal delivery; we are fine, keep moving'.  
Claire (4, 6-10)*

Midwives also rebuffed unwarranted interruptions:

*I was doing an internal examination and the next thing is, no knock on the door, (a doctor) starts bursting in, opening the curtains and I just shouted out, 'NO'. And he backed very fast and went out and did not come all the way in.  
Lucy (17, 25-28)*

Patricia also commented on this:

*. . . he (a doctor) just opened the door and I said, 'There is a bell, you ring the bell' . . .*  
*Patricia (9, 23-24)*

The midwife expected doctors or midwives to wait to be invited into the room. Margaret contrasted this with her experience in Hospital A and the old ways of working:

*. . . there isn't somebody coming in interrupting in the middle of a delivery with another woman on the other side of a curtain . . .* *Margaret (1, 25-26)*

When a second midwife was called to be in attendance for a birth the primary midwife required her to take a secondary role:

*. . . you may have someone (midwife) coming in and they are . . . saying (to the woman) 'you have to do this' or 'you have to do that', whereas at that stage I prefer if it could just be my voice, I hate someone coming in and dictating.*  
*Ann (7, 20-23)*

As will be explored in the next two sections, where the relationship between the woman and midwife was established, by the time of the birth, the midwife had managed care for the duration of the labour, supported her through difficult times and, despite uncertainties, midwives developed an understanding of what might be achieved. A new voice, from another midwife, could interfere with the relationship which had been built up between the midwife and the woman over time.

For midwives who had become used to their autonomy, interference was no longer expected or tolerated. Ann, who had worked in Hospital B, noted this change during the early days of the new hospital:

*It happened more initially when we moved, there was a lot of people (midwives) interfering in your care but now, no, the majority of (midwives) are happy, they just come and sit there . . . most of us try to do is just be polite . . . we have courtesy to clear things with each other.*

*Ann (3, 21-23)*

Interference had been common in Hospital A, particularly when midwives were relieved for a break.

This was reiterated by Sandy:

*People don't tend to interfere as much with your practice . . . Most people that would come in to cover you . . . they would just carry on what you were doing*  
Sandy (1, 15-20)

With the opening of the new hospital hierarchies could not be maintained and midwives could no longer comment or interfere with each other's practice.

### **13.7 Getting into the psyche**

As indicated by the language midwives used when they spoke about being with women in labour, this experience was different from how they had previously spoken about births. Midwives now seemed to have a greater sensitivity towards the women in labour, particularly when labour became intense, as Barbara explained:

*. . . you get a feel for the woman by being with them; you have to build a relationship to know where they are at . . .*  
Barbara (13, 31-32)

This was described by Lucy as 'getting into the psyche' (6, 46).

Barbara described this sense of intuition about the women in her care:

*I just got that feeling, I couldn't tell you, it was probably just intuition, that she actually wasn't going to have the (baby herself)... She was holding back something.*  
Barbara (8, 1-2)

There were several stories where the midwives described instinctive ways of knowing and anticipating outcomes for a birth which will be detailed in the next section of this chapter.

Each woman's labour is different and women go through various stages before the baby is born. Ann spoke of the language she used when labour was at a difficult phase:

*You need to keep reassuring (women) and you need to be confident, even in*

*yourself, you need to instil that confidence in the woman that 'you can do it, you are getting there, this is perfectly normal, every woman experiences this phase, it is going to end soon' . . .* Ann (6, 15-18)

Positive, reassuring supportive language emerged in many contexts. In this scenario, Ann sought to transfer her own confidence about birth to a woman experiencing doubts.

As discussed earlier, the importance of trust being established early was an important part of the relationship and this became more apparent as labour progressed. While reassuring the woman that all was well, the midwife had to remain confident herself. Several midwives used similar language in describing the trust required at the time of the birth:

*You kind of get a feel (for the woman) and you get her to build trust in you. The biggest thing with women in labour is that they trust you and that they have faith in you and that they have confidence in you and if they can see that you have confidence in them that they can do it . . .* Claire (7, 4-7)

If labour was particularly difficult for the woman, the midwife was aware that if trust was established, she could give the woman confidence and a belief in her ability to give birth. This was important as a delay in the second stage of labour could lead to an instrumental birth:

*I am facilitating her in what she is doing all of the time and I believe that she has got to believe in it herself so all the time I keep on giving that (belief), and speaking it, that 'you are doing it, well done, look at what you have done, wow, you are great, you are doing it'. Every time I just try and keep (the belief) in her and that she is strong and that she is able and that she is doing it. It doesn't work all the time . . . but in the ones that it works with, it works beautifully.* Lucy (4, 19-25)

The language that the midwife uses constructs a reality, which for Lucy, could lead to *beautiful* births (see examples later).

The midwives I interviewed could maintain their beliefs about birth but they also

recognised an uncertainty about the outcome. The midwife might anticipate a normal birth but there was always an uncertainty and as Mary stated:

*Things mightn't go according to plan sometimes . . .* Mary (1, 16)

If the second stage of labour was perceived to be long, the midwife had to consider whether to call for assistance. This was not always an easy decision for those who were committed to normalising birth:

*. . . and I know that during that time I was thinking to myself, oh here we go again, do I get the doctor now or do I wait. Is there a possibility, she can move the baby down? And you all the time query yourself, no matter how strongly I believe in it.* Lucy (14, 35-39)

Lucy was one of a few midwives whose dialogue indicated that she actively sought to empower women to take responsibility for their own labour and birth rather than relinquishing responsibility for this to others.

### **13.8 Labouring in the eye of the storm – sharing the beauty of birth**

There were many positive birth stories recounted by the midwives which I encouraged them to share. These stories reflected a different reality for the midwives and unlike the earlier interviews in Hospital A, 'normal birth' were no longer due to chance but were brought about by the actions of the midwife. Many of these stories reflected midwives' efforts to normalise a birth where they could, or at least try to provide the woman with an optimal birth experience.

In listening to these stories the midwives' freedom to practice was apparent. While the 'storm' of activity persisted outside, the room was a still space in the 'eye of the storm', where the midwives had opportunities to support normal birth. This granted both midwives and women an opportunity to go beyond 'satisfaction' with the birth, and encouraged them to engage with the positive, powerful and joyful experience that a good birth can be.

The first story is provided by Edel who was providing care to a woman whose labour was being induced:

. . . when I took over (her care) she was lying on the bed so I got her a birthing ball . . . She really didn't want the epidural but I was thinking the Synto(cinon) was up to quite a high dose . . . So I got her pethidine and she relaxed, she sat at the end of the bed . . . eventually she was feeling the pains and... so I got her gas and air and got her back out of the bed, got her walking around and obviously the (monitor and I/V) leads don't go that far, but eventually she was feeling a lot of pressure. I never examined her even though it was a four or five hour period, I just let her be. . . So then I just got her over the back of the bed and she was saying, 'I feel like pushing.' So I said, 'Breathe away, you'll be fine for another while, keep going.' And then just literally (I) put on a pair of gloves and delivered her, and she said, 'It can't be over.' . . . she just delivered. . . . Edel (6, 13-32)

What was particularly positive about this experience was the effect it had on the woman after the birth:

(For the last birth) she had a terrible time, she'd had quite a lot of stitches, and (this time her perineum) was intact and she said, 'I didn't think that could happen.' . . . and she was thrilled and she just started breast feeding straight away . . . and (later when) I brought in the wheelchair she said, 'What are you doing with the wheelchair?' And I said, 'I'm taking you upstairs,' and (she said) 'I can walk.' . . . so I carried the baby . . . Edel (6, 32-40)

Lucy provided a story where she believed that the woman experienced an orgasmic birth<sup>50</sup>:

. . . she was fully dilated . . . she was a PP (private patient)<sup>51</sup> . . . And (the consultant) happened to be on the ward at the time . . . she was labouring away beautifully and . . . And she was standing at the side of bed and every now and then she'd breathe in deeply and she'd have a contraction . . . so I told her that the consultant was on the ward, and he came in and I just say,

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<sup>50</sup> Women may have an orgasm during birth but this is not usually associated with birth in hospital settings.

<sup>51</sup> PP (private patient) was a term used for women who had booked private obstetric care. For these women a consultant obstetrician would attend the birth.

*'no sign of the baby yet, we are just waiting'. . . Lucy (11, 36-40; 12, 1 – 14)*

Lucy explained to the consultant that though she had not done a vaginal examination that she expected that the birth was imminent but:

*. . . an hour and a half later there was still no sign of the baby . . . she was not pushing at all . . . (I think that) she had an orgasmic birth, I am absolutely convinced that this is what this lady was having . . . she was more than happy in her second stage of labour . . . another half hour went by and still nothing . . . I said it to her that there was a possibility, unless the baby comes out very soon that (the consultant) is going to do an instrumental delivery, a vacuum or forceps delivery . . . And she went, 'Oh!' (popping sound of baby coming) . . . she just did it . . . and the husband and I just looked at each other! . . .*

*Lucy (12, 14-40; 13, 1-10)*

Lucy provided several stories of births which she had attended. This included one where the woman backed herself into a corner of the room:

*And she went in, around in between the window and the bed and the locker . . . and she leaned on the bed for her labour . . . So I just started (massaging her back) . . . I just stayed there and then she was there about an hour and ten minutes and then suddenly she starts moaning more and just that deep groan and I hadn't moved and I couldn't move and all I could think of, I knew that they baby was coming, was press the bell . . . and the trolley was pushed around to me and just opened the (delivery) pack and she just got lower and lower and lower and I grabbed a pillow off the bed and put it under her and this is where we were, squished right in the corner. But I think that she wanted that to happen, even though she had never vocalised it because she said it to me afterwards that she had decided with this baby that she wanted to do without anything and she did and she was so thrilled with herself. And I don't think that there is anything, if you get into the psyche.*

*Lucy (6, 28-46)*

Lucy stated that she did not probe women to ascertain their plans for the birth but tried to create an environment whereby women could express themselves as they wished. When women responded to this, it could lead to positive births. Lucy said

that her approach did not always work but when it did, it worked ‘*beautifully*’ (p. 171). She described births like this as being ‘*charged with energy*’ (10, 36).

Rose, who also spoke of making a quiet space, provided the following account of a birth:

*. . . then she found the toilet, sitting on the toilet... she actually spent about two and a half to three hours on the toilet as a comfortable spot . . . just getting up now and again . . . she would say, ‘I’d better go back into the room now’ I’d say to her, ‘Well if you are comfortable stay where you are, you are fine’ . . . She was back on the bed for the birth, kneeling and all-fours and she delivered on left lateral and it was all very normal and very nice. Those kind of things would stand out, for your own satisfaction as well, to guide her through it, and that was fantastic . . . she was considering epidural at the beginning in a very strong way because it was her first baby and she was 3 cms and such a long way to go, and . . . things worked well for her. It was a very satisfying experience all round afterwards*

*Rose (6, 11-45; 7, 1-4)*

Positive births were not always straightforward or natural events. Edel’s account above concerned a woman who was having her labour induced (p. 173) and, for these midwives, it was not a normal birth or a birth with minimal intervention that defined a positive birth. Rather, it was a birth with which the woman had a sense of achievement; it was this experience that was central. Unlike the earlier interviews, midwives no longer spoke of women being lucky to have this ‘*fantastic*’ type of birth. Midwives were active agents in making these births happen and when they occurred, it left them with a tremendous sense of satisfaction. Margaret’s birth story in Hospital A has similar aspects, in that Margaret was aware that she was an active agent in the birth (p. 93). However, Margaret described the woman involved as being lucky to have such a positive experience. In the birth stories recounted in the new setting, midwives no longer described women as ‘*lucky*’, and, the midwives were aware that their presence made a difference.

Amelia shared a story, which she considered led to a joyous birth. In this scenario the woman was encouraged to take various interventions:



*I had a lady recently, she was 7 cms when she came to me . . . She was labouring naturally and she was using her TENS and Entonox. But she just got stuck and it was a big baby . . . and at that stage I thought she was going to deliver within the hour so I said, 'I could break the waters and speed things up a little bit'. But she was still at 8 cms an hour later and . . . she was getting stressed . . . So when she got an epidural . . . she was 9 cms after the epidural and she pushed then, it was about 44 minutes of pushing . . . there was a lot of a sense of achievement at that birth as well, I think we probably needed even Syntocinon and it might have made it very painful for her . . . It is a sense of job fulfilment . . . she is so happy and you are so happy that everything went well.*

*Amelia (8, 2-26)*

This woman experienced several interventions in her labour before giving birth which, according to her midwife, was a positive experience. This reality may have been created through the woman's involvement in the decisions being made, despite the unplanned amniotomy, epidural and augmentation of labour. For the woman who had wanted to 'do it naturally', it is not known what she considered about her experience and the level of intervention. Amelia shared in the joy at the time.

Margaret had previously told me that she would stop being a labour ward midwife if she did not occasionally experience positive births (p. 94), now welcomed the privacy and lack of inference in this new unit. She provided a story of a woman who had very rapid progress in labour after being induced:

*. . . she was desperately looking for an epidural, a young girl, she was induced really quick and she is not going to make the epidural because (the anaesthetist) was just so busy and she . . . had been of labouring on the ball for a while and then she got up on her knees . . . and she just turned around and she was pushing, (and) I felt she was probably fully dilated, she was pushing herself and I said, 'it is fine you can continue if you want to push like that'. I felt she wasn't in control or comfortable and I said, 'do you want to change again?' And she said, 'yes'. And she delivered up on her knees, that was her decision.*

*Margaret (7, 6-14)*

Margaret told me this woman was very surprised to have achieved a vaginal birth

without the use of an epidural.

Ann's story of a woman giving birth without an epidural left the husband feeling surprised:

*. . . the woman was starting to become distressed and she was really contemplating an epidural, she . . . was finding things difficult . . . and I remember just saying, 'Look we are just going to try something different', and she reluctantly, very reluctantly went to the shower and we took the Entonox to the shower and she must have stayed in the shower for 20 or 30 minutes, and she did do it you know . . . she was pleased, but I find it is often the partner still, they are looking at you and saying, 'I don't believe you made her do that' you know*

*Ann (10, 18-26)*

In the above stories the midwives were aware that they were instrumental in facilitating the births described and shared in the achievement with the new mother. These positive births occurred even where interventions were being used.

As before, when a woman came to the unit in active labour and progressed rapidly, 'normal births' occurred, almost as a chance event:

*. . . a lady . . . with her second baby and she had a pretty tough time the last time, she ended up with forceps and she was hoping not to get an epidural. She came down and she was 4 cms and the next thing her waters went and she was making huge progress, the baby literally came out, it was so controlled, it was so calm, it was really nice, it was lovely.*

*Sheila (6, 14-18)*

While this was a rapid birth and could potentially have been distressing for the woman in labour, all that was required by the midwife was to remain calm. Midwives did not use the term 'real midwifery' to describe this type of birth. The account of this birth is similar to the *lucky* births described earlier (p. 93).

Midwives sometimes worked hard to achieve even a vaginal birth:

*. . . she would have been fully (dilated) at 8:00 . . . But still at 9:30 we still had no baby. But in the last half an hour, I knew we were going to have a*

*baby . . . If there is an arrest in the second stage, there is one or two positions . . . I have tried it before and it definitely worked . . . she was doing everything, she was pushing on all-fours, she was lying on her side, she was up and out of the bed. I said, 'will you get out of it (the bed)?', 'No I am grand I am wrecked' and I said, 'we are really at a point I think it will help you if you get out of the bed and do this', And she did and she was fit to fall down . . . But she did that position and it actually worked . . . Put one leg up on the chair or the bed, and it just changes diameters . . . Brilliant, she had a lovely normal, delivery. . . all was well.* Barbara (7, 10-32)

Though the views of the parents were not apparent this was described by Barbara as a 'brilliant' birth as an instrumental birth was avoided. Midwives felt they were doing a good job when they achieved a vaginal birth, what made it particularly good experience for them was when the women also considered that the birth was a very positive.

The time after birth was important for the midwife so that she could share with the woman this achievement. This explained why they did not want to rapidly vacate the room:

*... just having a bit of time to kind of, 'oh gosh look what we have achieved here together', kind of thing.* Meg (12, 21-22)

For all the midwives, there was a shared joy in the achievement of the birth particularly when a birth went well. Midwives carried this feeling with them for a while afterwards and Ann spoke of how she felt when going off duty:

*. . . going home I just felt this great sense of achievement because . . . when you have a normal labour, a normal birth, you do get a sense of achievement but I wouldn't go into the coffee room and discuss it with anybody, you know, there are(just) certain people that I know would appreciate it.*

*Ann (9, 26 – 30)*

As before, though midwives were aware of the other midwives who might value these birth stories, they did not often have the opportunity to share them with others.

Night time was still singled out as a time when midwives could make more space for normal birth:

*I find that nights is a lovely time, actually night duty is great . . . more often than not, during the night because you kind of have more time . . . .*

*Edel (2, 18-23)*

Though night shifts could be busy, because women were not admitted for induction the midwives were more likely to care for women in spontaneous labour.

It seemed unfortunate that the midwives did not share these experiences with colleagues. There was a sense that this type of birth was not valued in this large and busy technocratic unit but it is possible that these experiences were privately shared, probably with like-minded colleagues if the opportunity arose (see Chapter 7) and not for public discussion.

## **Conclusion**

This chapter has explored the central finding of this study which was the experience of midwives in their new environment, in particular, how practice was enacted when they worked in the relative isolation of individual labour rooms which paradoxically provided them with greater autonomy than heretofore. The title of this chapter, 'In the Eye of the Storm', reflects the space of the individual labour room which had now become the 'midwife's territory'. In Hospital A, midwives complied with the norms of the unit and worked under the potential for surveillance by their colleagues. There was the possibility that others could interfere. In the new unit, midwives had the freedom to decide for themselves what to do. As Edel explained this: '*you could do anything in that room and . . . no one would ever know*' (3, 1). This chapter largely described the midwives' experiences in this labour room, having escaped from the activity outside. Thus the sub themes emerged as; 'time and place - my space my territory', 'forming bonds', 'steering a course – the epidural question again', 'spending time, wasting time – a basket of strategies', 'breaking free', 'protecting the space', 'getting into the psyche', and 'labouring in the eye of the storm – sharing the beauty of birth'.

As midwives entered a labour room, they took ownership of the space, and were aware that they would be present until the birth was complete. The relationship with the woman had a new importance. Midwives created a space where the woman was *cocooned* and they believed that she could feel secure. They ascertained her expectations for the birth, and tried to meet these by providing a range of strategies which she could use. If an epidural was not part of the woman's plan, midwives made suggestions to steer her away from requesting one. Midwives associated epidurals with instrumental births and though there was more work involved, they had greater satisfaction, in supporting women through labour without one; particularly if the woman was also pleased with the outcome.

As midwives were largely unaware of what other midwives did, they used what resources were available to them within the room. The ball and the shower were often used, often with Entonox or pethidine to manage the pain of labour. Midwives also adapted the new beds to help women find comfortable positions. Leaning over the back of the bed or all-fours positions had become popular for the birth. When strategies worked, midwives had the satisfaction of this achievement particularly when the women were pleased with the outcome. As discussed in the last chapter the language that the midwives used when they spoke of individual birth was new. Midwives used terms such as '*fantastic*' and '*brilliant*' births and spoke of the '*beauty of birth*'. There was a joint sense of achievement when a birth went well. The changing conversations of the midwives reflected a new reality.

In the previous interviews women appeared passive in decisions being made about their care. In the new setting, the relationship between the midwife and the woman was stronger and women were more involved. This may have emerged as midwives spent more uninterrupted time with woman in labour. If all was straightforward others were not directly involved in the care and midwives seemed to have a greater awareness of her own responsibility for the woman's experience. The women giving birth had become the arbiter of whether the midwife's care was good and the strategies used had been appropriate at the time. Thus midwives shared in the achievement of a birth when it went well. This was evident in the all the birth stories told.

That this was a technocratic maternity unit was evident throughout all the interviews.

The room was a clinical setting with all the requirements for fetal and maternal surveillance. Fetal blood sampling or instrumental births, including caesarean sections could be performed quickly and doctors responded if the midwife had any concerns. Epidurals and induction of labour were so much part of every conversation and it was difficult for midwives to speak of a birth without these topics emerging. While midwives steered some women away from epidurals, they would also obtain one when requested, even where a birth was imminent. This was an expectation in the unit and midwives were aware that sometimes women complained.

In this large and busy maternity unit, midwives were breaking free. Midwives, such as Barbara and Margaret, had actively tried to normalise birth in Hospital A when the opportunity arose. They could do so now with greater equanimity that their approach would not be challenged. In achieving a positive birth, luck was no longer an issue. Other midwives adopted strategies that were available to them to support women through labour. Junior midwives were surprisingly confident and gained satisfaction when the outcome was good. Because of the lack of interference, there were greater opportunities to normalise the birth than before. Midwives had a range of strategies to use rather than resorting to interventionist therapies. Their experience of labour ward midwifery practice, in this large maternity hospital challenges some of the assumptions of institutional birth.

The central findings of this study will be discussed further in the next two chapters.

## SECTION 4 THEORISING THE FINDINGS

### CHAPTER 14 STREET LEVEL BUREAUCRATS WITH DAMAGED IDENTITIES

#### **Introduction**

This study was undertaken in two phases. The first involved interviewing six labour ward midwives in Hospital A, a maternity hospital which was due to close. In this unit practices were slow to change. The second phase of data collection consisted of interviewing seventeen midwives one year after services had transferred to a large new hospital (Hospital D). This hospital had three times the number of births than Hospital A and replaced three long established maternity units. In the new unit, despite the isolation midwives experienced when caring for a woman in labour, they also experienced greater autonomy in their work.

The findings from this study are discussed in two chapters using a number of theoretical frameworks which emerged from my engagement with these data. This chapter provides a discussion on the findings from the interviews with the midwives before the move (Chapter 7) and incorporates some of the challenges they experienced as they transferred to their new larger unit (Chapters 10, 11).

The discussion in this chapter draws from the work of a number of writers. Festinger is used to explore the dissonance revealed in the dialogue of the midwives as they engage in what appears to be conflicting beliefs. This was particularly relevant to midwives in Hospital A; they purported to support 'normal' birth but worked in an environment where intervention was the norm. Lipsky's work was resonant to both phases of the study as it explains the challenges encountered by public servants who are expected to provide client centred care, but, in their work environment, they are constrained by a lack of resources. The structure of power, particularly evident in the first phase of data collection, is explored using Foucault's concept of the Panopticon. Finally, Lindemann Nelson conception of 'damaged identities' is used to reflect on the narratives related by the midwives, to explore, how these reveal their identity as a marginalised group.

The more positive elements, which form the somewhat paradoxical findings of this study, was that the isolation the midwives experienced led to a freedom and autonomy in how they now practiced (Chapters 12 and 13). This will be discussed in Chapter 15 utilising Merleau-Ponty's work.

#### **14.1 Challenges for labour ward midwives in contemporary maternity care**

The ethos of the Labour Ward in Hospital A differed from the smaller sister maternity hospital (Hospital B). In Hospital A, the ethos was technocratic and bureaucratic, with routines and protocols in place to determine how midwives practised and birth was managed. Midwives had little autonomy in their work. Surveillance was a factor as any senior midwife or doctor could potentially enter a labour room and intervene in the woman's care. Privacy and individualised care were not valued, just progression in labour and a safe birth.

When Hospital B midwives were interviewed in the new hospital they informed me that they were encouraged to support normal birth and were given guidance and encouragement by midwifery managers on how to achieve this. There were few doctors around and while surveillance of the midwives was a feature, the use of oils, music and mobility had been encouraged. In Hospital A, apart from the limited use of mobility, and occasionally different positions being used for labour and birth, strategies to normalise birth were not encouraged or valued.

Data from midwives in Hospital A, resonated with the qualitative studies previously reviewed (Chapter 4) and it seems that, when hospital based midwives are interviewed, similar issues emerge. Thus, some of the findings from Phase I, namely: 'consensus of care', 'powerless to initiate change', 'immanently contested space', and 'changing practice and learning new skills' reflect the findings from the metasynthesis in Chapter 4. Two new themes emerged: 'new life and nice work' reflected the positive aspects of labour ward work; and 'impending uncertainty', which was specific to this study, reflected the planned closure of the hospital several months later.

From these early interviews and the literature reviewed, it appears that many labour ward midwives experience a dissonance surrounding the paradoxical imperatives that can be characterised as *birth is a normal physiological process but at the same time*



*technologies, interventions, and surveillance are necessary to ensure safe outcomes for the mother and baby.* Most of the midwives in Hospital A accepted the practices of the hospital in which they worked. Where there was discretion, they might have delayed doing an amniotomy, or encouraged a woman to labour without an epidural, but they maintained the practice of continuous fetal heart monitoring was routine, perhaps perceiving it as protection against adverse events. This is consistent with other reports which suggested that, where technology is available, there is a tendency for health practitioners to use it routinely rather than because it is always necessary (Buus-Frank 1999, Sandelowski 2000). For midwives in Hospital A, and to some extent in Hospital D, the universal use of CTGs for labouring women was not questioned.

As in earlier accounts of labour ward midwifery, while intervention and surveillance was evident, the midwives received greater satisfaction when they had the opportunity to support a woman through a natural labour and birth. In the birth stories recounted in Hospital A, where normal birth happened, it was often because the labouring woman progressed without the need for intervention and without much fuss. Margaret was the only midwife who spoke about the importance for the woman to have a good experience of birth, even if this was not straightforward. Three of the midwives (Margaret, Marie and Sandy) had agency when they spoke of the strategies they used to encourage or effect a normal birth, but there was an element of luck if all turned out well and the birth was a positive experience for both the woman and the midwife.

This contradictory approach in midwifery practice creates cognitive dissonance which has also been identified in studies from the UK (Hunter 2004, 2005) and USA (Kennedy and Shannon 2004). According to Festinger (1957), cognitive dissonance occurs when individuals feel discomfort or dissonance in holding opposing beliefs. To return to consonance, they alter their attitudes or behaviour to eliminate, or at least minimise the discordant perspectives. This was apparent in the interviews with the midwives in Hospital A, they purported to support normal birth but acted to align themselves with the technocratic ethos of the unit. When a midwife used a particular strategy they were not happy with, such as perform an amniotomy or suggest an epidural, cognitive dissonance theory suggests that any unpleasant consequences

associated with that choice will be minimised. To avoid dissonance, the person who made the choice will try to diminish the regret and personal responsibility associated with their choice (Festinger 1957).

As in other studies where cognitive dissonance was identified (Kennedy and Shannon 2004, Hunter 2004, 2005), the midwives in Hospital A largely counteracted the potential dissonance by acquiescing to the norms of practice. Despite their participation in all aspects of care, they did not take responsibility for the levels of intervention. Positive experiences of 'normal' childbirth occurred as a chance event. Some midwives sought to normalise birth if the opportunity arose and regained some coherence through 'lucky' experiences of providing 'real midwifery' (as defined in Chapter 4, p. 37) to enable some women to achieve a physiological labour and birth.

Sandy was the only midwife who had not reconciled her dissonance and continually voiced frustration and dissatisfaction with the practices in the unit. Others complained about the level of intervention but largely complied with the norms of the unit without evidence of emotional distress. This could be considered, in terms of Heidegger, as an inauthentic response. As Steiner and Reisenger (2006) explain this:

*Heidegger maintains that people are prone to ignore their own unique possibilities and to adopt the common possibilities they share with others (1996). These are the basis for conformity which Heidegger calls inauthenticity, which does not mean that conformists are not really human. It simply means they are not fully themselves. (p. 306)*

In Hospital D, dissonance was less apparent in the midwives' accounts as there were greater opportunities for them to authentically practice 'real midwifery'. The reasons for this will be explored in the next chapter.

Unlike other studies (Kirkham 1999, Hunter 2005), midwives in Hospital A did not refer to undertaking subversive practices, with or on a woman in labour, to avoid unnecessary interventions.

## 14.2 Street Level Bureaucracy

In both hospitals, midwives moved between caring for high risk and low risk women, including many whose labour was being induced or who requested an epidural. Midwives preferred caring for women without interventions but stated that they did not mind which woman they were allocated to at the start of their shift. Midwives in both hospitals saw themselves as part of a team of labour ward midwives, which required that they had the skills to work in all areas. Throughout the day, they managed the progression of women in labour as well as those coming for induction and were required to provide equal care for all. They did not meet the women before their labour commenced nor did they see them afterwards. In the new hospital, the tension for midwives between, providing optimal care for women (particularly following a birth), and, the pressure to complete tasks and transfer mothers and babies to the postnatal ward has been noted in other studies (Mackin and Sinclair 1998, Hughes et al. 2002, Deery 2005). The midwife returning from the transfer would be required to care for the next woman that she was assigned to, often missing out on her meal breaks or having the time to discuss or reflect on the previous birth.

Thus, the data in Chapters 7, 10 and 11, resonate with Lipsky's work entitled *Street Level Bureaucracy* (2010). The midwives interviewed were public servants, participating in a service which required them to process women through the unit as quickly as possible as part of the routine everyday work of a busy hospital labour ward.

For midwives, this processing of the women through a public health care system is consistent with the street level bureaucrats who:

*. . . must find a way to resolve the incompatible orientations towards client-centred practice on the one hand and expedient and efficient practice on the other (Lipsky 2010 p. 45).*

Lipsky asserts that, within the public sector, a lack of time and shortage of resources inevitably undermines the provision of advocacy. Labour ward midwives in a busy environment are required to juggle the needs of individual women with the needs of a technocratic system which does not value the individual woman or the midwives' capacity to facilitate a normal birth. This has also been described as the, 'with-

institution' rather than 'with-woman' approach to midwifery care (Hunter 2004) and maybe due to the need to manage a potentially overwhelming workload over which, midwives have little or no control (Finlay and Sandall 2009). Street level bureaucrats are front line workers who interact with the clients and make decisions about the services that are delivered but, as Lipsky (2010) states:

*Although street-level bureaucrats may sometimes struggle to maintain their ability to treat clients individually, the pressures more often operate in the opposite direction (p. 100).*

In Hospital A, a 'street level bureaucracy' was evident in the work of the midwives; the management of labour was largely routinised following a biomedical approach to birth with a range of technologies and interventions expected to be used either by the midwives themselves or following orders from doctors. The midwives stated that they tried to meet the needs of individual women but they also had to consider the needs of the unit, how busy it may be at the time and the doctors and other midwives around. Diversity of practice could be challenged and midwives who had concerns about the model of care felt powerless to bring about change. It was easier to comply than to be in conflict with their midwifery or medical colleagues. This was also found in a number of studies previously reviewed (Hollins Martin and Bull 2006, O'Connell and Downe 2009).

Lipsky (2010) provided an example of how street level bureaucracy functions using a hospital Emergency Room as an example:

*Hospitals attempt to develop elaborate protocols to help nurses determine medical priorities in emergency rooms. This is done in the name of optimising the use of available resources. But the assigning of priority categories also restricts the observations that can be made about a patient. Responding to the most salient symptoms may mean neglect of the whole patient of other conditions requiring diagnosis (Lipsky 2010 p. 198).*

Midwives in both hospitals spoke about the importance of their relationship with the woman in labour; however, in the initial interviews, their dialogue reflected an approach to care which was about surveillance of the woman and the management of the birth according to accepted protocols. The physical aspects rather than

psychological aspects of birth were prioritised. Progress in labour emerged as a mechanical and painful process for which women required, monitoring, support and adequate pain relief. The ability to provide strategies which support the psychological and emotional aspects of labour was not a feature of the midwives' dialogue. Woman seemed passive in this process; once the birth was complete, the woman and baby transferred to the postnatal ward and the labour ward midwife was required to be ready to care for another woman in labour.

The surveillance by midwives in the role of street level bureaucrats was focused on the aspects of labour and birth which could be monitored. Particularly in Hospital A, amniotomy, cardiotocograph monitoring and vaginal examinations were routine. A midwife or doctor could require these under the guise of the well-being of the fetus or labour progress. This would take precedence over the woman's experience of labour as an epidural could be provided if and when she became distressed. Lipsky (2010) contends that clients give their consent to the decisions made by street level bureaucrats because the recipients of the service accept the legitimacy of the service providers (p. 57). Clients may anticipate that dissent would not be productive or they may consider that they are being favoured by decisions which are taken on their behalf. Though the midwives claimed to be powerless to enact change, their dialogue indicated that, once norms were adhered to, they were largely in control of the situation.

It is recognised that health systems often involve relationships that are bureaucratic, hierarchical and authoritarian (Doyal and Pennell 1979). Unlike the data gathered later, in the initial interviews, apart from requesting an epidural, there was a noticeable lack of involvement of the woman in decision making about their care. Women were passive in the discourse of the midwives, who stated that women did not challenge the care provided. Throughout the earlier interviews midwives used the language of power, phrases such as *'we get women to . . .'*, *'the woman is permitted'* or *'allowed to'* were frequently articulated (p. 89). It has also been noted that labour ward midwives can exert power over women by withholding information, giving information in a hurry or making decisions on their behalf (Sinivaara et al. 2004). This unidirectional power with subtle wielding of authority has also been described as competitive power model, with one party being dominant in the decision

making process (Nugus et al. 2010).

That few midwives put the women at the centre of their dialogue has been highlighted in a number of studies (Russell 2007, Porter et al. 2007, Keating and Fleming 2009). In Hospital A, the labour ward midwives wanted the women to have a good outcome; they shared in the joy of a birth, but they also valued being part of a team and having good relationships with other staff. This is consistent with a bureaucratic approach to health care and is possibly explained by Ashman (2008) who maintains that for a harmonious workplace, the building of long term relationships with colleagues is more important to individual staff members than the short term relationships they have with their clients. Because the midwives did not challenge the practices in the unit, there was little opportunity to reduce the level of intervention. Midwives were thus complicit in the model of care provided. This is contrasted by the experience of midwives in Hospital D who could openly voice their concerns.

Despite the bureaucratic nature of public service work, Lipsky contends that street level bureaucrats often have discretion both in the delivery of services and in their interaction with clients. They thus have opportunities to prioritise certain clients or aspects of their work where this leads to greater satisfaction for themselves. Favouritism can thus be displayed. In both hospitals '*types*' of women were apparent in the dialogue of the midwives and all expressed dissatisfaction when women requested an epidural on arrival to the labour ward. As good team workers, they maintained that they provided equal care to all, but preferences were evident in their accounts. Sandy candidly informed me that, '*the woman gets the best from me at the beginning of a shift*' (7, 17-18) and there was also greater satisfaction and sense of achievement in caring for women in spontaneous labour, particularly when the woman wished to avoid an epidural. This was particularly apparent for those midwives who openly professed to prefer to care for women seeking a 'normal birth'.

In the new hospital there were many elements in the midwives' accounts of their activities which were consistent with Lipsky's work. The workload of the unit had to be managed by the midwifery managers as both women in spontaneous labour and those being induced were processed through the limited space with greatest

efficiency. When a birth was complete, the room was rapidly vacated and another woman admitted directly. At the time of the interviews the midwives were under pressure to open the Induction Room to facilitate a greater throughput of women. In this new space five women in early labour could be cared for by one or two midwives. This room, as well as the eleven labour rooms are almost always full. In contrast to this, there was little support for opening the Pool Room, a resource which would be of direct benefit to individual women in labour.

Lipsky's model of the public sector has been challenged by Evans and Harris (2004) who argue that *'the proliferation of rules and regulations should not automatically be equated with greater control over professional discretion and that paradoxically more rules may create more discretion'* (p. 871). In Hospital A, there was little evidence of midwives utilising professional discretion and, as in other settings, the dominant practices were based on the authoritative knowledge of both doctors (Arney 1982, Davis Floyd and Sargent 1997) and senior midwifery staff (O'Connell and Downe 2009). All of the midwives recognised 'other midwives' who were 'more interventionist' than they were whose practises could not be challenged. Barbara informed me that 'some' midwives say to *'put all primigravidas on Synto(cinon) when they get to fully (dilated)'* (7, 37). This influence of more senior midwives on midwives' decision making has also been reported elsewhere (Murphy Lawless 1991, Begley 2002, Hollins Martin and Bull 2005, Mead 2008), and with resonances of Lipsky's (2010) work, in Hospital A midwives complied with practice to ensure harmony in the workplace, manage heavy workloads and try to provide an equitable service for all women. In contrast, in the new hospital, once the midwives escaped the surveillance of the labour ward corridor they had some discretion in their work. This will be explored in more detail in the next chapter.

### **14.3 Structures of power in contemporary maternity care**

#### **14.3.1 Before the move – under the gaze of the Panopticon**

Apart from the dissonance and elements of street level bureaucracy that were apparent in these data, the traditional polarised view of the power structures within contemporary maternity care was also evident. It has been argued that maternity care is dominated by a biomedical discourse in contrast to a sociological or woman

centred approach, and Foucault's work has often been used to understand this (Arney 1982, Murphy Lawless 1998, Walsh 2006).

Midwives in Hospital A claimed that they had little discretion in their work as substantive elements of their practice were determined by others. The midwives were concerned about levels of intervention but perceived that they were powerless to bring about change. All indicated that 'midwifery' was not valued and their practice was curtailed. This obedience, socialisation and learned helplessness among midwives, has been highlighted by others (Kirkham 1999, Hollins Martin and Bull 2006). Midwives moderated their activities according to the possibility of interruption and interference with greater freedom experienced on night duty. At night, when fewer senior staff were around, interference and surveillance was less prevalent and midwives described greater autonomy in a woman's care.

Foucault (1977) used the concept of the Panopticon to consider how surveillance or what he called the 'gaze' is central to the operation of power. The Panopticon initially referred to the observational tower found in prison yards, whereby prisoners were aware of the tower but could not know if they were being watched at any particular time. For Foucault, disciplinary power cannot operate without the Panopticon or the continuous surveillance of the gaze and once individuals internalise the notion that they might be observed, they often become their own observers and enforcers, thereby turning themselves into 'docile subjects' who willingly comply with the demands of the establishment (Foucault 1979). Power structures are invisible until they are overtly challenged, but those who challenge the gaze, effectively undermine the authority of the establishment, reject the docile body, and arguably, engage in systems-challenging praxis (Cheyney 2008).

In Hospital A midwives did not overtly challenge the system and though they perceived that they were powerless in changing aspects of care, some of their actions may have reinforced the fundamental power structures and *status quo* (Hollins Martin and Bull 2006). The midwives interviewed in Hospital A, expressed dissatisfaction with the potentially unnecessary interventions yet did not see themselves as complicit in the system of care. They either trusted the outcomes of interventions, or were confident that others would be responsible for decisions made. In terms of Heidegger, this could be seen as an inauthentic response.



The majority of labour ward midwives in Hospital A had not practiced elsewhere and spoke of consensus and compliance. Midwives were largely interchangeable; one could replace another and alter a woman's care without any consideration of the need for discussion. This is explained by Foucault (1977), who claims that power:

*has its principle not so much in a person as in a certain concerted distribution of bodies, surfaces, lights, gazes; in an arrangement whose internal mechanisms produce the relation in which individuals are caught up . . . Consequently, it does not matter who exercises power. Any individual, taken almost at random, can operate the machine (p. 202).*

In the shared space, the practice of individual midwives was under surveillance and thus midwives self-monitored their behaviour, regardless of whether anyone else was involved or oversaw their work. Surveillance ensures that rituals are maintained and thus '*normalisation becomes how cases are described, judged, measured and compared with others*' (McCourt and Dykes 2009 p. 29). Care was routine and ritualised with successful outcomes, for mother and baby, the goal.

Foucault's work has been used to understand contemporary maternity care whereby monitoring and surveillance of pregnancy and birth emerged as an effective management system which would optimise birth and minimise risk (Arney 1982). It is generally considered that for midwives and women to avoid this gaze and escape from the Panopticon, childbirth must take place in out-of-hospital settings (Walsh 2006, Cheyney 2008). For women in labour, the midwife is part of this surveillance, but the midwives in Hospital A, were also under the 'gaze' of the Panopticon.

#### **14.3.2 After the move – disruption of the Panopticon gaze**

As described in Chapter 10, the opening of the new unit was chaotic and threw all staff into disarray. In the general disorganisation, surveillance, power structures and hierarchies could not be maintained as doctors and 'other' midwives were otherwise distracted. This led to a disruption of the Panopticon 'gaze'. In this large maternity unit there was no longer a consensus of care or compliance with accepted modes of working. The midwives had characterised Hospital A as a place where interference was common and innovation difficult. In the new hospital, as the chaos subsided, new ways of working emerged. Surveillance was absent and innovation essential as

the midwives worked in relative isolation (Chapter 12). Because the midwives did not know each other well, interference was no longer tolerated. The midwives became protective of the women in labour and established new ways of working to optimise the birth experience (Chapter 13). This led to a sense of shared achievement for both the women giving birth and the midwives who were assisting them. This had emerged following a disruption of the Panopticon 'gaze'.

In Hospital D, the midwives had greater opportunities for achieving a positive birth by actively doing 'real midwifery' and, as much as possible, they normalised birth. Midwives no longer spoke about positive births occurring by chance or luck. In this context of a large maternity unit the disruption of the Panopticon was an unexpected finding.

#### **14.4 Damaged identities**

To conclude my reflections on the midwives' practice experience in a technocratic environment, the birth stories related by them revealed much that was particular to their professional identity. Narratives of 'real midwifery' singled out aspects of practice, not necessarily everyday events, but something that epitomised their professional identity. The births which they gained greatest enjoyment from were where they were active agents in making them happen. It was often hard work and epidurals were rarely, if ever, involved.

To explore this concept I turned to Lindemann Nelson (2001) work on what she termed 'damaged identities'. This emerged, initially from, my reflection on the contested space which was particularly apparent in the first phase of data collection. This contested space in maternity care was also reported by Davis and Walker (2010a) who noted that within the contested spaces of childbirth:

*. . . constructions of midwifery compete with those of medicine for recognition, and, more importantly, authority. In the obstetric hospital setting where the constructions of medicine dominate, midwifery knowledges and practices are marginalised and this power dynamic shapes midwifery practice in this setting, in particular ways (p. 380).*

From conducting these interviews, with the labour ward midwives in Hospital A, it was apparent that midwifery knowledge and ‘real’ midwifery was marginalised and an almost idealised concept that impacted on the midwives in terms of their midwifery identity. This was also evident in the interviews with the midwives in Hospital D.

Lindemann Nelson argues that individuals become what they are and develop their identity in response to the language, institutions, roles and shared understandings of their society. She noted that this identity can become damaged from a master-narrative whereby, the conception of who we are, is determined, but not valued, by a more powerful ‘other’. Using stronger terms, Lindemann Nelson (2001) maintains that:

*The connection between identity and agency poses a serious problem when the members of a particular social group are compelled by the forces circulating in an abusive power system to bear the morally degrading identities required by that system (p. xii).*

This impacts on the moral agency of the individual and can lead to a relinquishing of responsibility for decision making.

Lindemann Nelson developed her theory of ‘damaged identities’ from exploring the narratives and dialogue of a variety of groups, including nurses, mothers, transsexuals and Gypsies. She considered that the anecdotes recounted within the various groups, which she termed counterstories, reflected the impact that imposed identities had on the group’s sense of self and wellbeing. The counterstories served to refute the identity imposed on them by a master-narrative, which was the otherwise socially shared understanding of the group.

Counterstories are used to regain moral agency and to resist an oppressive identity. In reflecting on the dialogue of a group of nurses, Lindemann Nelson considered that counterstories emerged:

*. . . when a powerful social group (doctors) views the members of her own less powerful group (nurses) as unworthy of full moral respect, and in consequence unjustly prevents her from occupying valuable social roles or*

*entering into desirable relationships that themselves constitute identity.*

*(Lindemann Nelson 2001 p. xii)*

These self-defining counterstories, which are not widely recognised outside of the group, portray a strong moral definition. They reflect values, experiences and commitments, and, for these individuals and groups constitute an identity (Lindemann Nelson 2001).

As the stories told are not valued by the more powerful other, they need to be constantly retold until they become valued. Individuals who share this same identity are the ones most likely to be interested. Counterstories are often told in two steps, the first identifies:

*. . . the story about the person or group to which the person belongs in such a way as to make visible the morally relevant details that the master narrative suppressed. If the retelling is successful, the group members stand revealed as respect worthy moral agents (Lindemann Nelson 2001 p. 7).*

Midwifery narrative about the nature of ‘real midwifery’ provides seemingly authentic accounts of ‘good’ midwifery and what makes a ‘good’ birth. The narratives, presented in this study, are similar to those that are reflected in midwifery and childbirth literature (Hunter 2003, Ólafsdóttir 2008). Midwifery narratives are usually portrayed in contrast to the dominant paradigm of contemporary, technocratic or medicalised maternity care and, as Walsh (2009) suggests: ‘*Both service user and maternity care professionals are suffering under the burden of quasi-essentialist and polarising versions of good and bad births*’ (p. 492).

According to Lindemann Nelson, the powerful group’s misperception of an oppressed group results in disrespectful treatment. This can impede group members carrying out their responsibilities or from making favourable decisions for individuals where there is some discretion. Midwifery literature provides evidence of hospital based midwives as an oppressed group (Kirkham 1999, Fahy 2007), and also of bureaucratic decision making (Porter et al. 2007). The dialogue of the midwives in Hospital A and Hospital D reflected some of these characteristics, particularly when speaking of issues outside their control. Midwives in Hospital A,

were not autonomous in their work, they did not feel valued yet, with only a few murmurs of dissent, they accepted and complied with the practices in the unit.

In both hospitals I heard many 'ideal type' birth stories which defined midwives' beliefs and values around birth, and, in many cases revealed their identity and moral agency. In Hospital A, there were narratives about spontaneous births, where the midwife had the opportunity to provide 'real midwifery' and were instrumental in keeping the birth normal. There were also narratives of resistance and despair which were stories of conflict, or conflict avoided. Counterstories open up the possibilities that group members can enjoy greater freedom to do what they ought. That midwives articulate these narratives, demonstrates a capacity for the repair of identities damaged by a master narrative.

In the new hospital, the birth stories recounted also reflected midwifery counterstories but midwives also spoke of midwifery autonomy and this was reflected in their narratives. The positive birth stories they shared with me, were not shared, or widely valued by others in the unit. Nevertheless their dialogue indicated a possibility for counterstories being used to repair their 'damaged identities' and to enable them to express a type of midwifery that reflected them as '*worthy moral agents*' (Lindemann Nelson 2001 p. 7).

There were signs of a change in midwives portrayal of their identity. Narratives of repair were apparent and there were many more 'ideal type' stories related. Midwives spoke about autonomy in their practice and consistently used positive language as they spoke about births and various aspects of their care. There was a lack of opportunity to share these stories with colleagues, yet for some midwives, alternative ways of doing birth (avoiding epidurals, vaginal examinations, different positions for birth and the use of the ball), were now established as an acceptable part of practice.

It has been noted that midwives' birth stories portray an identity in terms of the dualist thinking of 'good' and 'bad' (Fielder et al. 2004, Keating and Fleming 2009). The narratives of the midwives in Hospital D are in conflict with the dominant polarised narrative about hospital birth. In Hospital A, the midwives experienced conflict around birth, but in the new hospital diversity was accepted and no longer

challenged. Midwives' stories gave value to what they did rather than potentially accepting the value or identity imposed on them by others. Where the midwife has autonomy to practice the type of midwifery that she enjoys this is characterised as 'better' for women than the alternatives of a biomedical management of the birth. Thus, if, in an obstetric led labour ward, the ethos is right and surveillance is lacking, positive births are more likely to emerge.

## **Conclusion**

This chapter has focused on the aspects of labour ward midwifery which largely emerged from the experiences of midwives in Hospital A but also reflected some aspects of the data gathered in the new setting. From the beginning, cognitive dissonance was apparent as the midwives spoke about their work. The contrast between, the core philosophies of midwifery, with its 'with-woman' approach to care, and, support for 'normal birth', and the environment in which the midwives worked, was quite striking. In Hospital A, where intervention and technology was the norm, by complying with this, the midwives did not recognise their contribution towards this technocratic approach to care. As the data demonstrated, consonance was achieved by midwives' acquiescence with these norms and by not taking responsibility for the levels of intervention in the unit. Also important to most of the midwives, was that they occasionally provided 'real midwifery' for individual women, when the opportunity arose.

That midwives felt disempowered, and sometimes frustrated, in this public maternity service can be described in terms of Lipsky's (2010) street level bureaucrats with the additional consideration of the phenomena of damaged identities (Lindemann Nelson 2001). As was apparent from these interviews, and also the metasynthesis (Chapter 4), when a midwife has the opportunity to practice 'real midwifery' as demonstrated by their 'ideal type' birth stories, this was fulfilling for the midwife assisting the woman giving birth. These stories epitomise midwives' narrative about their professional identity and was evident in their description of their work. In Hospital A, when midwives discussed what could be constructed as 'real midwifery', it seemed to be an impossible dream. The midwives reported that they could not challenge how labour and birth was managed, but their dialogue reflected the

contested space between a cohort of midwives and doctors and the ‘other’ midwives who were advocates for more interventionist approaches to care.

In the new hospital, stories of normal birth or of normalising birth also reflected the hegemony of the biomedical setting and the ‘damaged identities’ of the midwives. However, the increased autonomy that the midwives encountered had to some extent helped to repair these identities.

Also considered in this chapter was the influence of surveillance and how it impacted on the midwives as they worked. In Hospital A, the midwives, under the surveillance of the Panopticon, self-regulated their behaviour in the expectation that they were being overlooked. In the new hospital, midwives escaped from this ‘gaze’ and this had enabled new practices to emerge. Midwives now had opportunities to orchestrate positive births (Kennedy et al. 2004), and, though these births were not recognised or valued in the unit, the midwives shared in the joy of the women when a birth went well. The positive feedback they received from these births was self-perpetuating and encouraged midwives to repeat the strategies that were likely to achieve this type of birth where they could.

Counterstories related in the new unit indicated some repair of midwives’ damaged identities. This will be explored in more detail in the next chapter.

# CHAPTER 15 THE SIZE PARADOX AND AUTHENTIC MIDWIFERY

## Introduction

As detailed in the last chapter, the account midwives from Hospital A provided of their experience and practice prior to the move was very much in keeping with previous work in this area. When the midwives transferred into their new setting, as the workload was considerably greater than anticipated, they encountered a storm of activity from the start.

When midwives entered a labour room they escaped from the chaos outside. Where previously there was the prospect of interference, they were generally free from surveillance and worked in relative isolation. When other midwives and doctors occasionally entered their space, their involvement in the woman's care was no longer expected nor tolerated. During the interviews, it often appeared that it was the midwife who was in control of all that went on in the room, but, as I reflected on these data, it quickly became apparent that there was more to the midwives' experience than this. As will be discussed in this chapter, the relationship between the midwife and woman in labour was stronger than it had appeared to be in the earlier interviews. Midwives had become advocates for the woman in labour, maintaining her privacy, resisting intervention and protecting her space for the birth.

Midwives followed hospital protocols for aspects of their practice but they also exercised their discretion in many aspects of care. In this new unit, midwives were generally unaware of how other midwives practiced and there no longer appeared to be a consensus of care nor any established modes of working. How midwives described their experiences in caring for women in labour differed from what had been previously described. As Sarah stated: '*you are very much on your own . . . you just get on with it*' (2, 21), and Mary repeatedly used the term '*sink or swim*'. The lived experience and life world of the labour ward midwives had changed.

I spent considerable time reflecting on these interviews, listening to recordings and reading transcripts before developing some understanding of this experience. As before specific issues began to dominate. The meaning that emerged led me to seek



new ways to understand and interpret the data. The notions of street level bureaucracy and power and control by dominant others, as discussed in the last chapter, no longer described the full story of the lived experience for these midwives. How the midwives' practiced when they escaped from the Panopticon gaze, needed greater explanation.

In exploring how the midwives articulated their practice, led me to consider how they used the individual rooms. As I did not observe them directly, an understanding of their use of space in the room came from their own accounts. In Hospital A, the restrictions of space in a shared room had been a constraint. How the midwives took ownership and made use of the individual rooms, in contrast to the busyness of the labour ward corridor, raised questions. Time also emerged as a significant issue as midwives spoke about their work. Progress in labour requires a measurement and awareness of time but now it seemed that a sense of timelessness emerged as the midwives described their *being* with women in labour.

The third issue that emerged was how the midwives described their relationships with women in labour. The midwife's relationship with the woman was more important than before. Women no longer appeared to be passive recipients of care and there was a sense that decision making was now negotiated or shared. Relationships with midwifery colleagues had also changed; midwives no longer worked closely together and were not familiar with each other's practice. They did not have the opportunity to get to know each other well. Yet, at the same time, because of the busyness of midwifery managers and doctors, the midwives relied on their colleagues to come to their assistance when required. As such, the experiences of the midwives differed in a number of ways from the data gathered earlier. The meaning they made of their experience reflected this difference.

This led me to seek a new way of looking at the data which was consistent with a phenomenological approach. The work of Merleau-Ponty (1962) emerged as having the potential to provide a guiding framework to explore these issues. Apart from space, time and relationships, Merleau-Ponty includes embodiment as one of the four existentials of phenomenology. On-going reflection on the data revealed that this concept was also present in the midwives' discourse. A brief exploration of Merleau-Ponty's approach to phenomenology and a justification for the selection of

these four existentials for this phase of the study is now provided. The relevance of these philosophical insights is then discussed.

### **15.1 Merleau-Ponty**

Merleau-Ponty continued Husserl and Heidegger's interest in phenomenological description of experience and shared Heidegger's commitment to understanding of 'being-in-the world' (Moran 2000). Heidegger's focus was on the abstract nature of being, whereas Merleau-Ponty was concerned with a science of human beings (Cohen 1987). He was also influenced by the *Gestalt* psychologists who highlighted the complexity of the environment in which reality is perceived. The Gestalt perception of figure and ground recognises that isolated objects only exist within the structure of the environment in which they are encountered. The background which delineates objects inevitably impacts on how individuals perceive these objects (Koffka 1935). Merleau-Ponty (1962) describes four existentials as belonging to the structure of the *life-world*: lived time (temporality), lived human relations (relationality), lived space (spatiality) and lived body (corporeality).

#### Lived time (temporality)

For Merleau-Ponty, an exploration of lived experience meant re-learning to look at the world by re-awakening our basic experience of the world. His perception was that time is part of lived-experience. As with the other existential philosophies, perception of time is rarely an objective position. Time is a concept through which individuals pass, whether consciously or not; it arises out of a relationship with encounters or events as experienced by the individual, body-subject. The future and the past are in states of eternal pre-existence as time is in the moment of being (Merleau-Ponty 1962). What is past or future can only exist in the present and it is only in the present that consciousness and time coincide (Thomas and Pollio 2004).

Within pregnancy and childbirth, the concept of time is ever present (Beck 1994, Albers 1999, Davis Floyd et al. 2001, Simonds 2002, Downe and Dykes 2009). Time in each stage of labour is documented and progress is an expectation against time. For Merleau-Ponty, temporality is the lived experience of time, not time in an objective sense, but it incorporates the continuities and discontinuities of time as it is humanly experienced (Todres et al. 2007). Thus temporality is an awareness of a

temporal way of being in the world yet, in much of everyday life, time only periodically comes into consciousness (Thomas 2005).

The midwife in caring for a woman in labour has a temporal awareness of time. She is required to balance and understand the past, be authentically present for the woman in labour, while anticipating and preparing for a future when the baby will arrive. In the interviews, the midwives also spoke of a past time, which included their regret about the closures of the old hospitals; some looked forward to the period after the settling down when their working conditions might improve. All described the present time as real, dynamic and constantly changing and challenging for all staff.

#### Lived human relations (relationality)

The next dimension of lived experience is relationality. This refers to an individual's lived relations with other human beings and the space shared with others (Merleau-Ponty 1962). As for the other existentials, a consciousness of relationships is not always present, and yet when a person encounters another, he is:

*brought into relation with an external being, the person may present themselves as being open to the other or shut off from it. If the qualities radiate around them a certain mode of existence, if they have the power to cast a spell . . . this is because the sentient subject does not posit them as objects but enters into a sympathetic relation with them, makes them his own*

*(Merleau-Ponty 1962 p. 248)*

As Van Manen (1990) explains, when individuals, as embodied beings, encounter another person, relationships, whether transient or potentially of longer duration, are formed. That other, a person, is always physically present in both space and time. First impressions of this encounter are confirmed or are changed over time, and, there is also a potential for deeper relationships to form.

It has been reported that, when it is at its best, the woman's relationship with her midwife is personal, intimate and has considerable significance for the woman and the event she is experiencing (Hallgren et al. 2005). For the midwife, the 'with-woman' relationship is a core component of her professional role (Kirkham 2000,

Stadlmayr et al. 2006, Lundgren and Berg 2007). However, as previously discussed, the relationship the midwife has with other staff may determine her capacity to engage authentically with individual woman in labour (Hollins Martin and Bull 2006, Porter et al. 2007, Deery and Fisher 2010), and, as described in Chapter 14, this may lead to midwives experiencing ‘damaged identities’. And as previously highlighted, the relationships workers have with their colleagues may be more important to staff members than the short term relationships they have with their clients (Ashman 2008). In the new setting, spending long hours with the woman in labour seemed to have led to a strengthening of the midwife-woman relationship and simultaneous, weakening of the midwife-colleague relationship.

### Lived space (spatiality)

Spatiality was the third concept highlighted by Merleau-Ponty (1962). He conceived this as being the space, largely unseen, through which the individual perceives the objects and people in his world. Spatiality is the felt or lived space. This is not the way objects are arranged in a setting, *‘but the means whereby the positing of such things becomes possible’* (Merleau-Ponty 1962 p. 243). This perception of space is both instinctive and individual. As with embodiment, the experience of spatiality is largely pre-verbal, accepted, taken for granted yet individuals react to spaces in certain ways which reveals that which is important for them (Todres et al. 2007). Thus, a phenomenological analysis of space requires the uncovering of that which is concealed along with what is revealed, uncovering the essence or meaning of the lived space for the individual (van Manen 1990).

To achieve a phenomenological understanding of midwives’ lived experience, it was important for me to consider the way they related to their situational context. While, the physical space of the room where the midwives worked was new, full of equipment and supplies, they endeavoured to minimise the impact of this, by dimming lights and playing music. This helped create a less clinical ambiance.

According to Merleau-Ponty, it is the perception of space and things that gives meaning to objects. Thus perception is derived from and is revealed in the relationships connecting the person to their world (Thomas and Pollio 2004). When the midwife establishes a relationship with a woman, she ascertains where she is

from, her occupation and, family circumstances. This places a person in their situational context and assists in identifying the lived-space of the other (Thomas and Pollio 2004).

The analysis of the physical space, as described by the midwives, revealed that they used the room in new ways. The room they shared with the woman became their own, their territory until the woman transferred out or the midwife finished her shift, relinquishing the space to the midwife who would replace her. They did not leave the space very often, and were rarely visited by other members of staff. It is within this space of the labour room, that privacy was maintained by the midwife, that the woman becomes a mother. It has been reported that the space where women give birth has the potential to be a spiritual space (Foureur 2004) but this is rarely encountered in institutional settings (Hall 2008).

#### Lived body (corporeality/embodiment)

According to Merleau-Ponty, there is an underlying dialectic between a person as a body and the world where it is located. Merleau-Ponty (1962) distinguishes the body-subject from the body-object. The body of others is presented as subject-object whereas it is through the body-subject that the person perceives the ways in which objects appear. As with the other existentials, the concept of embodiment is both revealed and concealed. It is not encountered in objective space but is present, on the margin of all that is perceived. Consciousness of bodily presence is not a feature of awareness until the body experiences change, such as hunger, tiredness or pain. This requires a recognition of bodily presence (Thomas and Pollio 2004), and as people have agency and are self-determining through the choices they make, the conditions in which they live can constrain but do not determine a body (Sadala and Adorno 2002).

The concept of embodiment or lived experience of body has previously been used to explore the experience of recipients of health care (Thomas and Pollio 2004, Hov et al. 2007, Blaaka and Schauer Eri 2008, Walsh 2009a). Once I considered the appropriateness of using Merleau-Ponty for this stage of the study, a question that arose in reflecting on the data was, whether it revealed how midwives appear and express themselves both in their own eyes and in the eyes of other people. Having

considered midwives' moral agency and 'damaged identity', I was now curious to explore if their embodied experience of midwifery was revealed or had being changed by their move to their new environment. From the first interviews in Hospital D it was evident that the midwives were required to be self-reliant in the care of the women in labour. This autonomy was not apparent in the earlier interviews. The data also revealed that this autonomy, led to a sense of freedom and vulnerability, and conjured up a range of emotions and experiences for the midwives that had not been revealed or discussed in other studies.

### **15.2 The four existentials and the size paradox**

For Merleau-Ponty the four existentials of lived time, lived space, lived relationships and lived body can be distinguished from each other but are not separate; together they form a unity of the life world. These existentials constitute how human beings come to experience and create meaning of their world. Time, space, objects and individuals are indeterminate with the potential for meaning but actual meaning emerges only when consciousness is engaged (Crotty 1998).

Reflection on the analysis of the data from the second phase of the study indicated that revealed time (temporality), relationships (relationality) and space (spatiality) were evident in the midwives' meaning of midwifery in this unit. Further reflection revealed body (corporeality/embodiment) as also present in the discourse of the labour ward midwives. Having moved to the one large unit the midwives had escaped from overt surveillance and they were no longer required to comply with established norms; as this was a new setting, standard routine practices had not yet been established. Respondents stated that they did not know how other midwives worked, and, apart from adherence to policies about induction of labour, or caring for high risk women, for the other women in labour, there were essentially no norms. Variations in practices were evident from the data and midwives had to decide for themselves what was appropriate in any given situation. They thus found new ways of working.

The insights obtained into the study from considering the phenomenological approach of Merleau-Ponty will be outlined in the remainder of this chapter.

### 15.2.1 Temporality - the lived time of midwives' experience of birth

*it is all about steps and not thinking (that the birth) is going to be soon, just about spending time and wasting time.* Edel (4, 30-42)

*no sign of the baby yet, we are just waiting'. . .* Lucy (12, 14)

*(or after a birth) . . . you could be told that you are taking (too much time) there is another lady and to hurry up, you know, have her out of the room.*

*Edel (16, 9-10)*

The paradoxical nature of women's experience of time in labour has been described as fluctuating between fast and slow (Beck 1994) and the rhythms of labour and birth have also been described (Maher 2008, Walsh 2009b). Midwives have been noted to balance these rhythms of childbirth, by staying in the background or becoming sensitively engaged with the woman as required (Hallgren et al 2005).

In reviewing the data for midwives' lived experience of time, two contrasting dimensions emerge. The first one emerged from the workload of the unit, the throughput of women, the activity of staff, and the need to respond rapidly to changing circumstances. This dimension of time was discussed in Chapter 14 where the challenges of public servants working with limited resources were addressed. All staff experienced the same pressures and lack of time to do their job well.

The other, more surprising dimension of time was reflected in the dialogue of midwives as they provided one-to-one care. A midwife could spend up to twelve hours with a woman in labour, until the birth was complete or the midwife went off duty and relinquished care. When entering a room at the start of her shift, if a woman was in early labour, the midwife was aware that this labour could take all day (or night). A midwife, while remaining composed, confident, and supportive of the woman, had to repeatedly reassure herself that all was well and that some progress was being made towards the birth. Midwives' references on time often referred to getting meal breaks which could be erratic. Even here, midwives returned quickly, not wishing to lose their connection with the woman, nor wanting others, to make decisions about a woman's care (p. 158). During the interviews I was consistently told that labour *takes time*, but following a birth, perception of time changed back, to

that of the street level bureaucrat. If another woman was waiting, the midwife felt pressure to complete the required paperwork and vacate the room quickly. If the room was not immediately required, the midwife could relax, reflect on the birth, encouraging longer skin to skin care and supporting the first feed (p. 122). I was repeatedly told that when a birth was a joyous event, the midwife shared with the new mother a joint sense of what had been achieved.

As midwives spoke of this dimension of time, 'the *being* with a labouring woman', they revealed a component of time which differed from everyday dimensions of time and could seem almost timeless. There was a sense of a past, present and future to midwives' dialogue; the labouring woman may have just arrived or been there from the previous shift. The midwife opens herself to the woman's story, her identity, labour history and her expectations for the birth. Relationships are established, and if all is well, reciprocity and mutual trust developed, and the midwife and woman could await the birth. It is often considered that labour ward work is regulated by the clock (Simonds 2002), and a sense of time is ever present for labour ward midwives, particularly for women whose labour was being induced or who had an epidural. Yet, despite the busyness of the unit, the labour ward the midwives repeatedly said that if these were not being used, there was no rush for a fast labour and birth.

Where birth could be awaited, some of the midwives seemed to create a sense of timelessness in the small room. They kept others outside and protected the woman from interference, while continuously reflecting and reassuring themselves that all was well. This timelessness was created in the inner space of a small room in the midst of a busy labour ward outside. In previous accounts of hospital midwifery, midwives spoke of 'going with the flow' (Kirkham 1999, Crabtree 2004, Hyde and Roche-Reid 2004), reflecting their compliance with norms in the hospital setting. Now while the midwives were required to go 'with the flow' of the activity in the unit and responded to various demands, they could also go 'with the flow' of the woman and accompany her through the rhythms of her labour; responding to her needs and supporting her through to the birth and a short time beyond.

It has previously been noted that midwives experience a clash between linear time, which involves processing women through the labour ward space, and, 'women's time' which is not linear, and is the 'time of reproduction, the family and personal



relationships' (Bryson and Deery 2010). Being with women in labour requires patience with labour and patience with time; watching and waiting for labour to progress. Yet the midwives were required to remain alert to a potentially changing situation, or to help out, if required. Midwives thus balanced and kept watch of the rhythms of labour in 'linear time' while observing and having patience with the flow and pace of labour for individual women in 'women's time'.

Nonetheless, progress in labour was expected and the partogram completed as required; midwives remained alert to physical changes and behavioural cues but unless there were concerns about maternal or fetal wellbeing, the duration of labour was not questioned. This waiting and apparent suspension of time has been described as 'watchful waiting' (Annandale 1988) or 'waiting on birth' (Walsh 2009b); terms more generally applied to midwifery in out-of-hospital settings. Paradoxically in these data, such 'watchful waiting' took place in a large and busy obstetric unit. It now seemed that hospital-based midwives could also wait for events to unfold. Barbara's friends wondered how she might spend twelve hours with a woman in labour, often without much to do; for Barbara this was part of the labour ward midwives' world (p. 154).

Consciousness of time has long been recognised as an issue for labour and birth (Thomas 1992, Simonds 2002, McCourt 2009a). Frankenberg (1992) argues that the creation and control of power through the medium of time is central to medicine and that the '*contradiction of temporalities and of aspects of body boundaries is sharpest between social and natural motherhood on the one side and class- and gender-constructed obstetric medicine on the other*' (p. 25). Similarly, Thomas (1992) argues that in the social and cultural construction of childbirth, time is '*of the essence*' (p. 56) and it has also been shown, that from a historical perspective, that concepts of time have cultural significance (Mccourt and Dykes 2009). In Ireland, the development of 'Active Management of Labour' led to stringent management of time for women in labour (see Elaine p. 154). This policy for labour management was reported to be effective in removing the uncertainty and 'tedious hours' of labour and also reducing the overcrowding of hospital labour wards (O'Driscoll and

Meagher 1980 p.1)<sup>52</sup>.

The midwives I interviewed during both phases of data collection, spoke of labour being ‘actively managed’, but this term was used loosely and generally referred to the use of epidurals, inductions of labour and caesarean sections births. In Hospital A, midwives and doctors could intervene in any woman’s labour and order an amniotomy or oxytocin. Anaesthetists could wander in and offer an epidural. For midwives in Hospital D, doctors and senior midwives were otherwise distracted and, unless there was a problem that needed attention, there was little prospect of any interference in a midwife’s care.

Labour progress has alternatively been described as a ‘*complex chaotic physiological process not just based on time*’ (Winter and Duff 2009 p. 88) but this way of seeing birth is difficult to sustain where progress in labour is noted on the White Board for all to see<sup>53</sup>. Time is relevant to labour ward midwives as, even without interventions, labour is categorised as rapid or slow according to pre-defined criteria. The midwives in the new hospital, because of the lack of surveillance, could take a more flexible approach to time. Several avoided the usual time fixing measurement of vaginal examinations and used other signs of progress such as the ‘purple line’ or observation of the woman’s behavioural cues. Unless the midwife raised a concern about ‘time’, this approach to monitoring progress was now tolerated. Lucy spoke of a discussion about a woman in the second stage of labour who had booked private obstetric care. Without a vaginal examination, the consultant was content to let the midwife decide if the woman would require assistance for the birth (p. 174)<sup>54</sup>. Others spoke of their satisfaction when the fetal head appeared on the perineum and full dilation could be recorded (p. 166). Midwives who facilitated ‘longer’ second stages were aware that views on this differed among the midwives (p. 154). Summoning a doctor because the second stage was ‘too long’ and the woman may need the assistance for the birth, was a challenge. Doubt and uncertainty could creep

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<sup>52</sup> This approach to labour management is still endorsed by the National Maternity Hospital (Holles St) in Dublin.

<sup>53</sup> The White Board was placed in a central position at the Midwives’ Station and recorded each woman’s progress in labour. It provided an overview of the activity in the labour ward at any time.

<sup>54</sup> The 2<sup>nd</sup> stage of labour lasts for a few minutes or to up to three hours. The expected length will be determined by local hospital policies. If the duration exceeds this or if the midwife considers that progress is not adequate, she is required to summon a doctor. An instrumental birth or caesarean section may result. It is usual to confirm that the woman has entered the 2nd stage of labour by performing a vaginal examination.

in and the midwife had to remind herself to continue to believe that the woman could do it herself (p. 171).

This flexibility with time emerged from the dialogue of midwives interviewed in Hospital D, but was not apparent in the interviews conducted prior to the move. In Hospital A, the midwives worked to the norms for the unit. If labour was not progressing, there was an expectation that an amniotomy would be performed or labour augmented with oxytocin (p. 82)<sup>55</sup>. In the new hospital, midwives had greater discretion in the woman's rate of progress. Midwives, who were patient for birth to unfold, coped with the uncertainty as to when the baby would arrive, yet were aware that they were accountable for the decisions they made. For midwives who were anxious about 'longer labours', it may be that there were residual components of the unseen pressure (self-surveillance of the Panopticon), or that their previous experience and socialisation to labour ward midwifery work had led to a distrust longer second stages of labour.

Whether midwives and doctors differed in their perception of time in labour is not clear from this study, but it is evident that the midwives interviewed had different views about this. This was reflected by Elaine who had difficulty adjusting to this labour ward because the rigorous time management of labour that she had previously experienced was not now practiced. Claire also appeared more cognisant than the other midwives of a need to process women quickly through the space of the labour ward if women were waiting for a room (p. 123). In addition, once there was any intervention in labour, dimensions of time changed; while midwives continued to use diverse strategies to support women, the constraints of time were mediated by the need to monitor the woman and fetus more closely.

It has been highlighted that time in labour and birth is socially constructed and open to different interpretations (Downe and Dykes 2009). Society has internalised the current biomedical understanding of time in childbirth (McCourt and Dykes 2009), and these hospital based labour ward midwives knew the rules. McCourt (2009b) suggests that with the power of hegemonic knowledge, coercion becomes less

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<sup>55</sup> Amniotomy may lead to more rapid progress in labour, oxytocin increases the strength and frequency of uterine contractions. Both procedures increase the pain that the woman experiences and may lead to further intervention

important in maintaining dominant ideas as these are internalised and operated by people within the institution. This is consistent with a Foucauldian approach. However, these data are more nuanced. Foucault (1977) notes that within institutions where authoritative knowledge is enacted and maintained it is also resisted and changed. While obstetric practices were normalised and internalised in the unit, several midwives had also found ways around this, and had developed new ways to resist, change and manage both space and time in childbirth, not often recognised in hospital settings.

### **15.2.2 Relationality - the lived relationships of midwives' experience of birth**

*You kind of get a feel and you get her to build trust in you. I mean the biggest thing with women in labour . . . is that they trust you and that they have faith in you and that they have confidence in you and if they can see that you have confidence in them.* Claire (7, 15-18)

The attitudes and behaviours of caregivers are more important to women's satisfaction with their labour, than the pain they experience, their pain relief, or any interventions utilised (Hodnett 2002). Meaningful relationships between midwives and women have long been recognised as a central component of contemporary midwifery practice (Siddiqui 1999, Pairman 2006, Lundgren and Berg 2007, Ólafsdóttir 2008). In the first phase of data collection, midwives spoke of the importance of relationships, yet essentially, relationships with women in labour were not exclusive to one midwife. Others could approach and become involved in care, and midwives could be required to care for two women in the shared rooms. In Hospital A, midwives were under surveillance and the relationship with other staff could be subservient, or compliant, with elements of oppression evident in the data.

In the new setting, surveillance was no longer a feature and midwives' viewed their colleagues as peers, there to provide assistance when needed, but not to interfere unless this help was requested. On the occasions when midwives mentioned attempted interference, this was resented and could be stridently rebuffed. When a second midwife was present for the birth, the primary midwife remained in a lead role, and resented if the other midwife became too directive (p. 169). The relationship that emerged from providing uninterrupted one to one care seemed to

have enacted a greater responsibility by the midwife in striving to obtain for the woman an optimal experience of the birth. Midwives demonstrated a greater personal investment in the outcome of a woman's labour. A positive working day involved having a good relationship with the woman in labour, achieving positive birth experiences with a good outcome, and having a supportive relationship with other staff. Hierarchies were no longer apparent.

As the midwives did not have an opportunity to meet women before labour, it was when they first encountered each other that it took a little time for a relationship to become established. As Lucy stated: '*I introduce myself and if . . . they are in early labour you have more time for that, introducing and acclimatising to the space*', (6, 36-38). Midwives engaged in introductory conversation and often used this time to complete some of the required paperwork. This discourse had the potential to establish connections between them (p. 156) which, according to Thomas and Pollio (2004), places the person in their situational context and assists in identifying the lived-space of the other. Midwives also ascertained the woman's expectations for her labour and birth so that they could be sensitive to her needs as labour progressed. Midwives sought to achieve a reciprocal relationship and where this could be formed; they negotiated and discussed aspects of care, were respectful of the woman's preferences and provided a supportive environment for birth. When this led to a positive birth experience, the midwife shared, with the woman, a sense of achievement about the birth. Labour and birth was an everyday event for these midwives and not all births resulted in positive experiences for the women or the midwife. The everyday work of the street level bureaucrat, as discussed in the last chapter, made it difficult for midwives to maintain the same enthusiasm for each woman and each birth (p. 189).

Relationships between the woman and her midwife are at their best when reciprocity as is at the heart of this relationship (Fleming 1998). Hunter (2006) suggests that the concept of reciprocity has not been fully explored in midwifery literature yet this is assumed to be present in partnership relationships which involve a degree of interdependence between midwives and mothers. For relationships to become reciprocal, both the woman and the midwife must be open to establishing a relationship which is meaningful for both. While this may seem altruistic on behalf

of the labour ward midwife (who encounters many labouring women each day), is it not often considered that this relationship may have a pay-back for the midwife herself. Lipsky (2010) maintains that affirmation and appreciation from clients is central to public service workers' job satisfaction and sense of a job well done and Hunter's (2006) work on community midwives identified how feeling appreciated by the woman was both professionally and personally affirming. "*Getting to know' the woman by providing continuity of carer was important for facilitating authentic and trusting relationships'* (Hunter 2006 p. 316). Reciprocity facilitated the community midwives in their midwifery work. For the midwives in my study, who had relatively short term relationships, the ideas that underpin the model of effective midwife–mother relationships were apparent.

For these labour ward midwives, relationships had to be established quickly, particularly if a reciprocal relationship was to emerge. Edel recognised the importance of reciprocity suggesting, once the initial paperwork was completed, that the woman's partner took a break as she found that, often the woman '*opens up when she is on her own a bit more, just relaxes and gets to know you'* (11, 36-37). Some midwives sought reciprocal relationships so that trust was established and the woman would feel secure and respond to suggestions or directions made, particularly when the birth became imminent (p. 156-158). This had the potential to control and direct the woman to accept interventions but could also be used to support the woman to achieve what she wanted for the birth (Freeman et al. 2004, Hallgren et al. 2005). Seeking to establish, trust or reciprocity, when labour was advanced and the woman distressed, was not always easy to achieve (p. 157). Hunter (2006) contends that the degree of reciprocity invested in the relationship influences the level of emotion work involved for the midwife and, as will be discussed later, the midwives were often emotionally involved in the birth.

Nevertheless, the relationship between the midwife and woman in labour is inevitably asymmetrical as the midwife, with her professional knowledge and familiarity with the environment holds the power, and can thus exert control. Because of this, it is important for the midwife to establish a rapport whereby the woman can relax and feel safe (Hallgren et al. 2005). In the new hospital, the midwives accepted responsibility, not just for the birth, but also for the woman's

experience of her labour and birth. This had not been apparent in the interviews undertaken prior to the move. In the new hospital, midwives were aware of taking a chance when encouraging women to labour without an epidural and complaints had been made by women who perceived that their request for one had been denied (p. 130). Midwives, such as Claire, negotiated epidurals with women as Claire did not want her to regret her decision later (p. 159). Avoiding vaginal examinations or tolerating longer second stages of labour was also unconventional but were undertaken to provide women with a better experience of her birth.

Attending and ‘presencing’ are two other components of the midwife-woman relationship which Fleming (1998) suggests are difficult to realise in hospital settings. While the midwives spoke of the variety of women they cared for, attending and ‘presencing’ was evident in some of their discourse. Once the relationship was established, midwives could ‘attend’ the woman, anticipating her needs, or suggesting strategies to distract her at various stages of labour if she was becoming distressed or considering an epidural. ‘Presencing’ was evident in some of the stories recounted, this was by described Lucy as enabling women to get ‘*into the psyche*’ (p. 170); in this space, the midwife is attuned to the woman’s sense of *being*, creating a place of safety, where both time and place can recede.

As labour progresses, the emphasis the relationship between midwife and woman may change from one of ‘being’ (presencing) (Fleming 1998), with ‘watchful waiting’ (Annandale 1088), to one of ‘doing’ where the midwife is more overtly supportive and guides the woman through transition and the second stage of labour to the birth (Hallgren et al. 2005). Anderson (2000) suggests that midwives can create an unobtrusive atmosphere which can facilitate the woman to ‘*feel safe enough to let go*’. Several midwives I interviewed indicated that if all was well they did not direct the woman, remaining unobtrusively supportive throughout labour until the baby was about to be born. This has been also described as midwifery guardianship, and it has been suggested that where ‘*the woman can release responsibility for guardianship to the midwife she is most able to fully experience and respond to her bodily sensations making instinctive birthing more likely*’ (Fahy and Parratt 2006 p. 47). According to the midwives interviewed some women (and their partners) were surprised when a baby emerged without much fuss (p. 173). Instinctive birth experiences and

midwifery guardianship are not commonly associated with obstetric units where there are high levels of intervention. Of particular relevance to this study, is that, there were many more positive birth stories revealed in the new setting than had been apparent in the first phase of data collection. This seemed to be facilitated by the isolation of the midwives, the lack of surveillance and a lack of interference in their care. This was also reflected in the language that the midwives used around birth.

Needless to say not all midwives enact this type of relationship with women, and even those that did; they did not experience it with each labouring woman. There were times when midwives felt unable to autonomy in their practice and be explained by the emotional work involved in labour ward midwifery (Deery and Fisher 2010). Midwives also encountered women who expected or required intervention, and also women to whom unexpected events occurred. For these women, as noted by Freeman et al (2006), if they are actively involved in decision making, an optimal birth experience can still be achieved and these midwives recounted several birth stories where they experienced a joyful birth despite a labour trajectory which may have been far from 'normal' (see p. 176).

As discussed in Chapter 2, the debate around 'normal' birth has led to terms such as 'unique normality' (Downe 2006) or 'optimal birth' (Kennedy 2006) as being useful to recognise the diversity and uniqueness of the birth experience for individual women. This acknowledges that women can have a positive experience of birth even where intervention is required to ensure best outcomes for mother and baby. Similarly, Blaaka and Schauer Eri (2008) highlight how contemporary labour ward midwives move between different belief systems, a biomedical system, based on science and technology, and what they described as '*a phenomenological tradition that focuses on the needs of women in relation to the birthing process as a whole*' (p. 345). They consider that within the labour room, there is a 'battle' between management of labour where the use of epidurals and continuous fetal monitoring are expected rather than unusual procedures. This struggle, '*affects midwives' ways of doing midwifery, their thinking on what is safe and secure compared with what is risky, but also their way of thinking about the body*' (Blaaka and Schauer Eri 2008 p. 348).



This struggle and potential for conflict was apparent in the interviews with midwives in Hospital A, but alternative ways of working in hospital settings have also been previously described (Freeman et al. 2006, Davis and Walker 2010b). Without observation of these midwives as they worked, I can only comment on the information that they provided. My understanding from this data is that, because midwives were providing one to one care, they sought to understand individual women's hopes and intentions for the birth in order both to provide supportive care and to also assist her in achieving an optimal birth experience. It has previously been shown, that where midwives work in partnership and involve women in the decisions about her care, that the needs of individual women can influence midwives' decisions, rather than protocols and hospital routines (Davis and Walker 2010b). The woman's birthing autonomy can thus be maintained by relational concepts such as the woman's trust and the midwife's acceptance of responsibility (Freeman et al. 2006). As Lucy informed me, it is also important that the woman believes in this herself (p. 171).

Nevertheless, these labour ward midwives also functioned in a street level bureaucracy and when functioning as 'street level bureaucrats', a language of power and control became apparent in their dialogue. In these situations, midwives appeared to control the environment in a supportive but perhaps benevolent way (p. 156-157). Labour became a process which required efficient management, rather than an opportunity to enable women to give birth with confidence without analgesia or intervention. These midwives worked with their perception of 'best' practice, what the woman wants for her labour, but also made suggestions of alternative courses of action and discussed all plans for care.

### **15.2.3 Spatiality - the lived space of midwives' experience of birth**

*keep it quiet and calm and the music . . . pull the blinds, dim the lights and  
you have got a lovely setting straight away . . .* Rose (3, 16-21)

*You could do anything in that room . . .* Edel (2, 42)

*I don't take any notice of the room, or bed it is just whatever way the woman  
is . . . just whatever way that she comes in and uses the room . . . I don't  
change it around . . . I would be conscious of not having the lights blaring*

*and the curtain is over the window . . . asking her does she want music*

*Lucy (4,19-33)*

*the only thing you can provide for her as a change from the bed is the gym ball, you sit her out on the gym ball and she is on continuous monitoring and she is on the ball and on Syntocinon drip . . . they try them for a while anyway . . . she is limited to where she can go and the ball is literally at the side of the bed but it is as a change from the bed that you'd introduce it to her anyway*

*Rose (3, 35-37; 4, 1-9)*

It is in the labour room space that midwives spent much of their working day and in which the meanings of childbirth and midwifery are therefore contested and constructed (Davis and Walker 2010a). Once the midwife and woman entered the room neither moved outside much. Women did not walk the corridor nor use the bath very often; midwives quickly returned from their breaks or from assisting another midwife at a birth. When midwives spoke of the items they used in the room to support labouring women, they referred to what was new. The labour beds were both liked and disliked, the birthing balls were now employed extensively, and the *en suite* shower was used by some but not others. This represents the 'figure and ground' or *gestalt* for these midwives at that time. The labour ward was now a familiar environment but the new elements invoked comment. The use of the ball, the shower, or alternative positions for the bed, were adopted, promoted or ignored depending on the preferences of the individual midwife.

According to Davis and Walker (2010a), the spatiality of places is constituted by furniture, equipment, signage, decor and design, which invests and is invested with meaning. When I considered the concept of spatiality, I reflected on the data and questioned the 'figure and ground', within this space. What was revealed and concealed in this space for midwives as they cared for woman in labour. What was their perception and meaning of this experience, the labouring woman in the context of the environment, the room and factors outside the room, in this world of a large busy obstetric led labour ward? The concept of spatiality in this context implies 'felt space', and, the space the midwife and woman shared was technocratic, full of equipment and supplies, potentially impacting on midwives working there (Seibold et al. 2010). Midwives stated that continuous fetal heart monitoring was difficult to

eradicate and from their experience of the 'Home from Home' room, it appeared that birth could not take place without a resuscitator being present (p. 132). Each room contained the equipment required to provide women with a pain free labour, manage high risk care or deal with obstetric emergencies. Birthing balls were available, music could be provided and lights dimmed but other than these there was little in the room to make it appear less clinical. Midwives did not comment on the technocratic environment for birth but accepted this as the norm, yet they were glad of the privacy for women and the increased autonomy they now experienced.

Women's views on what creates an optimal birth environment in a hospital setting has not been well researched, but a place that provides a sense of security and privacy are considered important (Ogden et al. 1998, Hodnett et al. 2009). An NCT Survey reported that having an adjustable bed, a clean room, privacy and an en suite toilet were important, as well as the space to move around (Newburn and Singh 2005). It has been reported that the standard hospital birth setting serves to medicalise birth in the mind of woman and it has also been argued that the labour ward bed should be removed from centre stage (Walsh 2000, Gould 2002). A contrasting view is provided by Fannin (2003), who suggests that creating a home like environment in a hospital setting does little to normalise birth when the trappings of technology are readily available and the philosophy is underpinned by medical control. The physical aspects of the birthing space have the capacity to create potentially opposing concepts of surveillance or sanctuary and the more comfortable and familiar the environment is for the woman, the safer and more confident she will feel. Where the space deviates from this ambience, the more likely it is that she will feel fear and possibly emotional distress (Fahy and Hastie 2008).

The views of women were not sought in this study and it is probable that, just as their views on satisfaction of labour differ, women's views of the birthing space would also vary, some perhaps welcoming the availability of technology (Fenwick et al. 2005) or perhaps having this as an expectation in a modern new hospital. Green and Baston (2007) reported that women have increasing expectations around intervention in labour and it is clear from the accounts provided by these midwives that the level of inductions, caesarean sections and epidurals in the unit were not all derived from medical control but reflected the wishes of the women themselves.

From the data in this study it appeared that, while both women and midwives may feel reassured by the ready availability of machines and equipment, the harsh features did not create a positive space for labour and birth. As a consequence, midwives who were sensitive to the 'felt-space' of the room, tried to create a positive ambience whereby the woman could relax and feel secure. If all went well, midwives could feel '*cocooned*' with the woman in the room (p. 150), so that within this outwardly technocratic space, a safe and secure environment could be created for labour and birth.

As individuals react to spaces in different ways, analysing place requires a recognition that its concealed or secret components, which according to Lock and Gibb (2003), can reveal the power of the place as certainly as those that are more readily accessible. For the midwives who had adjusted so recently to this environment, as they entered a labour room, this space became 'theirs', to share with the woman and her partner. The language they used reflected that this was their 'territory', to use as they wished (p. 153). Midwives endeavoured to help the woman and her partner relax and they made the space feel safe, they spoke of dimming lights, playing music; shutting out the clinical aspects which could then potentially merge into the background.

The bed and equipment dominated the area and the technical components of labour management were not ignored. On arrival women were often commenced on a CTG and had various assessments which would require her to be in the bed. Midwives spoke of encouraging mobilisation as soon as the work of admission was complete, but this was not universal and would depend on the expectations and willingness of the women. While the midwives all stated that mobilisation was important, as there was little space, the use of the ball or the shower were the two strategies most frequently mentioned as alternatives to the bed.

As previously highlighted, a bed creates a place to which labouring women are drawn to and can lead to them becoming enculturated into state of dependence (Walsh 2000, Lock and Gibb 2003, Hodnett et al. 2009). This was evident in the dialogue of the midwives who said that it was often an effort to encourage women to leave the bed. Barbara spoke of an expression of disbelief in a woman's partner when she persuaded a woman to mobilise in the second stage of her labour and

subsequently avoided an instrumental birth (p. 178).

Seibold et al (2010) explored the concept of birth space for labour ward midwives and found that the physical environment, although important, was not the most important factor in creating an optimum space. The philosophy of care of the organisation and/or the individual midwife had a stronger influence on the woman and her experience of birth, than the physical environment. Midwives were influenced by their perceptions of risk and also by the doctors who could enter a room and enquire about progress. Symon et al. (2008) found that women's perception of spaciousness was associated with their overall satisfaction with surroundings and facilities but though space for mobilisation was important this was bound by the philosophy of care which determined the use of the space. In the current study, midwives had become protective of the space for the woman and when doctors came around, they used strategies to encourage them to move on (p. 168). It did seem that the philosophy of the individual midwife towards birth was potentially more significant than the environment in creating an optimal birth space. This was apparent from the midwives' language about making use of the space and the resources within it. While all had the same opportunities to create an optimal environment for birth, the approach of the individual midwife made a difference as to how much this was enacted.

Similarly, the strategies midwives selected to support women through labour were based on either their previous experience (Hospital B midwives) or their personal beliefs about birth. Where innovative practices were used, these seemed to have emerged out of an authentic desire to support the woman through the pain of labour, without recourse to an epidural. The midwife had to suggest strategies, providing support and encouragement, imbuing a belief that birth could be achieved without an epidural. Midwives did not want to 'control' the women, and sought to have them involved in any decisions required (p. 156-157). Some relinquished control, endeavouring to create space where the woman felt safe and instinctive through her labour and birth. Sometimes this did not work, but when it did, it worked *'beautifully'* (Lucy 4, 17).

Inevitably, the midwives were influenced by their environment, all the equipment required for intervention was in the room, epidurals could generally be obtained with

ease, and doctors were nearby to for instrumental births or caesarean sections. Midwives used what resources they considered appropriate and all spoke of Entonox and pethidine as being useful. Epidurals were provided as requested but several midwives steered woman away from these and used a range of alternative resources that were available to them within the room.

From a phenomenological perspective the midwives moving to the new space of the maternity hospital brought their historicity with them from their previous experience. While Hospital A was considered to be ‘very medicalised’ in its approach to care (see Chapter 7), for Hospital B midwives there had been an ethos around normal birth (p. 183). Nevertheless, the use of the ball was new for all. This had been available in both units but had previously been ignored or ridiculed; now it had become an acceptable resource (p. 163). It is not clear how the midwives learnt to adopt new strategies. Mary, the most junior midwife interviewed, stated that she remembered them from class (p. 147), midwives from Hospital B spoke about the culture of normality there, one midwife from Hospital B spoke of her surprise when she discovered that there were midwives from Hospital A, who had skills and were supportive of normal birth. For all the midwives, their personal philosophy for birth could now be expressed, without fear or oppression, and thus midwives were now free to enact their own beliefs about birth.

#### **15.2.4 Corporeality - the lived body of midwives’ experience of birth**

*I have had about four deliveries now with the ‘all fours’ . . . I had only seen one in my training, but it is lovely . . . So it is a fabulous position to give birth in . . . just get them to ‘full dilation’ beautifully but as soon as they get to ‘full dilation’ and they turn it is just lovely.* Mary (8, 31-33)

*. . . a beautiful experience . . . ‘That was lovely, she did so well and she was brilliant’* Edel (14, 29).

*. . . isn’t it wonderful not to diagnose somebody fully (dilated) from a VE (vaginal examination), you diagnose them . . . when you see the vertex on the perineum, that is lovely.* Barbara (7, 24-26)

*Those kind of (births) stand out, for your own satisfaction as well, to guide*

*her through it, and that was fantastic . . .*

*Rose (7, 3-4)*

*just having a bit of time to kind of, 'oh gosh look what we have achieved here together', kind of thing.*

*Meg (12, 21-22)*

*. . . going home I just felt this great sense of achievement because . . . when you have a normal labour, a normal birth, you do get a sense of achievement but I wouldn't go into the coffee room and discuss it with anybody, there are certain people that I know would appreciate it,*

*Ann (9, 26 – 30)*

These quotations reflected some midwives' experience of birth in a large technocratic obstetric hospital with almost 9,000 births per year. In Hospital A, during the first phase of data collection, the dialogue around birth was that it was '*always special*' but the language used did not reflect '*beauty*', or something '*fantastic*', which, when a birth went well, gave the midwife, together with the woman, a shared '*sense of achievement*'. This was a new element in the midwives' discourse around birth and not something I anticipated as I started on this study. It surprised me that within the relative isolation of the technocratic labour room, that these hospital based midwives had the potential to enact powerful experiences of birth. In Heideggerian terms, midwives had access, to woman's experience of *being* in birth, which they recognised and treasured. This is part of the joy of being a labour ward midwife. These positive births were no longer chance events, and while they did not happen on every occasion, when they did, they were hugely valued, and, as Lucy stated, '*student midwives are blessed if their exposure is good*' (14, 39).

Other than the sense of personal achievement midwives experienced around this type of birth, and some of their frustrations, the midwives did not talk much about themselves. Their frustrations, discussed in the last chapter were directed towards, their workload, the level of inductions and the lack of breaks in their work. Midwives also spoke of feeling isolated, unsupported, and what they missed from their previous maternity units. But while they spoke of '*isolation*' they also spoke of being '*cocooned*', and having '*autonomy*'. There was now a greater respect for the midwives and as Lucy, stated, '*(the doctors) know whether you have got experience or not*' (5, 28) and even junior midwives expressed confidence, having learnt from their own experience of being with women in labour.

As was evident in Chapter 12, midwives could paradoxically feel both vulnerable and insecure, or confident and autonomous, depending on what was happening at the time. Yet it was within this new setting that nascent midwifery practices had emerged. Midwives' could adopt a flexible approach to time in labour; their relationships with women were based on trust and reciprocity; and the 'space' of the labour room had become their own, which they could use as they wished. This facilitated the increased use of birthing balls, mobilisation and alternative positions for birth. Through using embodied ways of knowing, non-standard methods for monitoring progress in labour were used and some births came as a surprise to the woman and her partner when they occurred without much fuss. The secluded space for labour and birth impacted on midwives' practice and the individual woman giving birth now seemed to be the only arbiter of the midwife's care. Where midwives encountered '*beautiful*' births; this sustained their belief in birth encouraging them to repeat this experience. Thus, when opportunities arose, they enacted 'real midwifery', an approach to care which had become self-perpetuating.

Positive birth experiences were no longer described as rare or *lucky* events for the labour ward midwives and, while not making claims of expertise (Downe et al. 2007), for all those I interviewed, it has been reported that the expert midwife can '*orchestrate labour*' and '*create or manoeuvres the birth space for women*' (Kennedy et al. 2004). This was now evident in the discourse of these midwives. Midwives have also been described as providing midwifery guardianship, whereby the midwife exercises jurisdiction over the woman in labour but uses this to create and maintain harmony between the woman, the midwife and the space for the birth (Fahy and Hastie 2008). As Davis-Floyd and Davis (1997) states, '*Mothers and midwives mirror one another, it's a dance, the woman has to trust the midwife and the midwife has to trust her woman for that bouncing back*' (p. 337).

Lundgren and Dahlberg (2002) suggest that while midwives are open to provide individualised care, they are also responsive to pathology, and may '*seize the woman*' (p. 161), when they find that her labour exceeded her ability to cope. For the midwives in the current study, an epidural, or other forms of intervention, was always available. Even the midwives who tried to avoid interventions would on occasion recommend it for individual women.



Davis and Walker (2010c) report how case load midwives in New Zealand have an embodied understanding of the need to negotiate biomedical space and the obstetric gaze of the maternity hospitals and policies for maternity care with the '*the intellectual spaces of their own discursive constructions of childbirth*' (p. 605). This process or activity was theorised as '*making space*' which, for the New Zealand midwives involved moving between home and hospital settings with the potential of encountering '*obstetric constructions of childbirth*'. Unlike the New Zealand midwives, the midwives in my study encountered '*obstetric constructions of childbirth*' every day. Yet their relative isolation in the midst of a busy labour ward, and their desire to establish reciprocal relationships with women, provided them with opportunities to express their embodied constructions of childbirth, mediating this experience between the safe management of women experiencing a biomedical labour and also more naturalistic approaches. This could involve '*spending time and wasting time*' (p. 162), and, avoiding interventions where they could. In their isolation, midwives had to confront their personal constructions of childbirth and express the 'type' of midwife that they themselves were. Having responsibility for care meant that they had full responsibility for any decisions made. They selected their own preferred strategies to support women; these would be negotiated with the woman in labour and were appropriate to her expectations and individual experiences of labour.

Midwives who are supportive of normal birth have to be comfortable with the inherent ambiguity and uncertainty of labour; and are also required to manage risk and balance the expectations of individual women (Annandale 1988). In this study, there were concerns about the lack of support for inexperienced midwives who were often quick to call a doctor where an experienced midwife might perceive that all was well (p. 147). Yet these junior midwives also spoke confidently about their work and they too were aware of the capacity of 'real midwifery', and the potential for powerful birth experiences.

It is likely that the language midwives use, frames the reality for women in labour. This was revealed when the midwives spoke, quite naturally, of the beauty of birth, and shared with me, a range of powerful and positive birth stories. The sense of fulfilment midwives experienced when they were aware, that their input into a

woman's care contributed to a positive birth, was extremely rewarding and made their work worthwhile. The birth stories related, contrasted with their frustrations and negative aspects about the work in the unit, the autonomy they now experienced was restorative and, as indicated in the last chapter, had gone some way to restore their 'damaged identities' and gave added value to their work. The beauty of birth is not often recognised in midwifery, particularly when birth takes place in hospital settings, and as Walsh (2008) maintains:

*The focus on beauty corrects the imbalance in contemporary childbirth on its framing as a medical event. The focus on virtue reminds us of the relational dimension of birth as well as placing women's experience at the centre. She is the central actor in the drama of birth. The rest of us are supporting parts and 'extras' (p. 74)*

Where midwives' beliefs about birth come from was a question that this study could not answer. For some it was an innate belief about birth which may have preceded their entry to midwifery (Barbara), some stated that they learnt from the women themselves (Marie), while others spoke of learning from other midwives to be patient and wait for the birth to unfold (Edel and Mary). Within this busy unit, the understanding that '*labour takes time*' may have been brought into this unit from the Hospital B midwives who spoke of this as being present there. This concept had not emerged in the interviews with midwives in Hospital A, where they experienced pressure for labour to progress. Prior to this study there was evidence that all midwives do not have the same beliefs about childbirth (Hallgren et al. 2005, Porter et al. 2007, Mead 2008), but there is also evidence that some midwives can comfortably move between different approaches to birth (Berg and Dahlberg 1998, Blaaka and Schauer Eri 2008, Blix-Lindström et al. 2008).

In reviewing their dialogue in relation to what it would reveal or conceal about the concept of embodiment, was the most challenging of Merleau-Ponty's four existentials to uncover. According to Deery and Kirkham, (2007) the value placed on the technical competence and efficiency of midwives leaves little space for emotion work and the data from this study challenged my understanding of the embodied experience of the midwives' world as I engaged with the hermeneutic circle. According to Merleau-Ponty (1962), consciousness is intrinsically linked to

the body as one cannot exist without the other individuals therefore shape their world by their embodied experience of interacting with it. Central to this idea is intentionality the way of the body being and acting in the world which is the sum of bodily experience, physicality and emotions (Walsh 2009a). In comparison to the earlier interviews in Hospital A, now all midwives, even the most junior, spoke with assurance and confidence about their work. They had become familiar with their environment, moving between the various demands that were made on them from the biomedical management of women who required it and to perhaps more authentic meaningful approaches to childbirth where this could be achieved. While not always successful, they tried to ensure that women had the opportunity to have an optimal birth experience. These were the births that provided midwives with greater satisfaction, both physically and emotionally. It seemed to enact something joyful and transcendent when midwives do, or, are in the presence of 'real' midwifery and powerful and positive, almost life affirming births.

## **Conclusion**

These midwives' practice was dominated by the biomedical model of childbirth, in that they worked in a unit where intervention rates remained high. The somewhat surprising finding of this study was that midwives could escape from some of this practice and their experience of midwifery in this large maternity hospital challenges some of the assumptions of institutional birth.

In this chapter, the four existentials of Merleau-Ponty were used to guide my reflection on the data gathered. From the commencement of the second phase of data collection it was apparent that midwives' experience of midwifery was different from the earlier interviews. Merleau-Ponty's four existentials of perception: lived space (spatiality), lived time (temporality), lived body (corporeality) and lived human relations (relationality) were useful to explore this experience and examine the world of the midwives in the labour rooms of this large hospital.

As has been discussed, in terms of midwives' perception of time, two contrasting versions emerged. There was the external time dimension caused by the workload of the unit which created activity for all staff. The labour ward was always full and women were often waiting for a room to become free. Yet despite this external

pressure, once the midwife entered a labour room she could escape this dimension of time and enter, or create, a sense of time for the woman in labour. This was time for the woman to labour, which was not rushed, and could seem almost timeless. While the midwife remained conscious of linear time, monitoring the woman and fetus at pre-defined intervals, and updating the information on the White Board, in this time a space could be created for the woman to give birth.

In terms of relationality, this issue has consistently been highlighted as an important component of women's experience of labour and birth. In the first phase of data collection, midwives' relationships with their colleagues was important to them but when this was compared with how they spoke about the women in their care, it almost appeared as if the women were passive objects of care. While these midwives had stated that relationships with women are important to them, this was not reflected in their dialogue about women they accompanied through labour. Hospital midwives have been criticised for being responsive of the needs of the institution (with-institution) rather than enacting a with-woman approach to care (Hunter 2004). After the move the contrast on how midwives spoke about their relationship with women was quite striking. When speaking of their care, the midwives now placed women at the centre of their dialogue and it seemed that their relationships with women had new meaning. Reciprocity and trust was now important to the midwives and where this could be achieved they gained considerable satisfaction from providing care and assisting at the birth. They worked closely with the woman to meet her needs and expectations, making decisions and negotiating aspects of care, striving to obtain an optimal birth experience for the woman in labour.

Spatiality was the third concept I explored which considered how the midwives I interviewed perceived the space of the labour room, and, how within this, they created a space for the woman to labour and give birth. Once the midwives entered this space, it became their own and they used this in different ways. Midwives varied in what they prioritised, some spoke of trying to create a pleasant ambience to minimise the clinical aspects of the space, others spoke of encouraging women to make this space 'their own'. Midwives used the objects and space in the room in different ways, using the beds in different positions, encouraging mobilisation and the use of the ball and the shower. They rarely left this space, spending several hours

with the woman, within the room until the birth was complete. While they left the room for various reasons, they quickly returned, not wishing to break their connection with the woman in labour. This was tenuous and could be lost. Midwives protected the women in this space, others were not welcomed and interference was rebuffed.

The final concept explored was corporeality of embodiment; the midwives lived experience of body. This was the most challenging to uncover as midwives spoke more about what they 'did' rather than what they felt about what they 'did'. It was largely through reflecting on the language the midwives used that their embodied experiences were revealed. This emerged from the positive language that they used around caring for women in labour and supporting them through the birth, decisions would be made and midwives negotiated aspects of care with women in labour. Midwives sought to achieve an optimal birth and where women experienced a positive birth experience; they shared in the woman's joy at the birth and saw this as a joint achievement. This joy was reflected back to them by the women, and, while they did not have the opportunity to share this with other midwives, they felt good about their day.

As became apparent in this study, once the midwives settled into practice in Hospital D, they had greater opportunities to authentically create positive births by actively doing 'real midwifery' in this large and busy maternity hospital.

## CHAPTER 16 REFLEXIVITY CHAPTER

Prior to my conclusion of this thesis, in an attempt to be open and transparent regarding this work, this brief chapter will outline my reflective journey in undertaking this study. Through this I hope to demonstrate how my engagement with the hermeneutic circle led to the findings presented here, which provide an understanding of the meaning of the experience of labour ward midwives. To achieve this understanding required that my pre-understandings would merge with the data. In this chapter I hope to reveal my preconceived notions and how these changed as the study progressed. This change in understanding had implications for the findings, discussion and conclusion of this work.

My position, prior to commencement of this study, was to challenge and berate the medicalisation of childbirth. During my personal experience of midwifery practice, I had witnessed a gradual increase in, inductions of labour, continuous electronic fetal heart rate monitoring, epidurals to manage the pain of labour, and the increase in caesarean sections for women. Over a number of years I had kept watch on the caesarean section rates in one of my local hospitals and noted that when epidurals became more available, caesarean section rates rose over 20% for the first time.

When I had worked in midwife practice, I spent over one year as a labour ward midwife. At that time, women laboured in bed, routine amniotomy and two hourly vaginal examinations were performed, with I/V oxytocin administered if adequate progress was not achieved. Episiotomies were common, particularly for primigravid women. At the time I did not question these practices as they were part of my midwifery education programme. Active Management of Labour was the norm and home birth largely unknown.

My role models were those midwives I worked with who were most supportive of women in labour. During that time, while I did not perceive myself as a 'normal birth' midwife, I sought opportunities to care for women who came to the labour ward with a 'birth plan'. These women were avoided by some of my colleagues but I gained satisfaction in trying to help these women achieve the type of birth that they had planned. While I cannot recall any particular strategies I used to enact a non-interventionist birth, I recall being supportive of women and reassuring them, that

their hopes for the birth could be achieved. Caesarean sections and inductions of labour were not high during this period and most women were in active labour when they arrived in the labour ward.

As I later moved into midwifery education and became more aware of the debate around childbirth, my concerns were heightened when students would occasionally report, that they hardly ever saw a 'normal birth'.

I blamed these changes on the 'medicalisation of childbirth'; I was also aware of some midwives being more interventionist than others. I would debate this with midwives I know who actively sought to 'normalise' birth when the opportunity arose. These midwives often shared their birth stories with me. I thus began to hold midwives responsible for going along with the increasing intervention in the unit and was aware of the difficulties my colleagues experienced if they attempted to challenge the system of care.

Reading on this topic broadened my perspective, particularly the work of Robbie Davis-Floyd and Jo Murphy Lawless. I had also acquired a 1980 copy of *Active Management of Labour* and was surprised how much this book had influenced the practices in the unit where I worked. This was my perspective on contemporary childbirth as I commenced work on this study.

From a theoretical perspective, the challenge of the metasynthesis was the first difficulty I encountered and challenge to my perspective. I had a good understanding of quantitative methodologies, but in undertaking this work I gained a deeper understanding of the processes involved qualitative work, particularly in interpretive methodologies. The findings of the metasynthesis revealed the universality of hospital based midwives' experience of midwifery. Undertaking this work enabled me to confront and shed some of my biases. My study of contemporary childbirth was moving away from a polarised view and leading to an understanding of the complexities confronting this issue.

Following the metasynthesis, I now considered that, the midwifery care women receive in labour will not just depend on the place where they give birth. For women who give birth in hospital, the midwife they encounter may well consider her wishes,

but this will be compounded by the midwife's belief system, the workload on the unit, the time of day, and the other midwives and doctors who may become involved.

My next challenge was to enter the world of hermeneutic phenomenology. The language of phenomenology is difficult to comprehend and I regretted my lack of knowledge of the ancient Greek philosophers, whose work underpins 20<sup>th</sup> Century philosophy. As I moved through the works of Husserl, Heidegger and Gadamer, through the writing and rewriting of this chapter, I eventually arrived at an understanding that enabled me to move forward with this study.

As I commenced the first phase of data collection, while I endeavoured to keep the precepts of phenomenology with me during the interviews, I was somewhat disappointed. Either my lack of experience at phenomenological interviewing hindered me in probing beyond the everyday nature of the midwives' dialogue, but against this, even as I was interviewing the midwives, I was also conscious, that when they spoke of their work and their experience, this data resonated with the studies I had reviewed for the metasynthesis. I eventually understood that, due to the nature of their environment, with the potential for surveillance ever present, that these midwives had few opportunities to engage authentically with women in their care. Their experience resonated with the previous studies in this area.

It was while I was working through the analysis of this data that hermeneutic phenomenology became real for me. The process involved in listening to recordings, reading and re-reading transcriptions, moving through data from individual midwives, to comparing sections of coded data, for example how midwives spoke about birth. My engagement with the data moved between, the immediacy of the interview (when listening to recordings), the experience of individual midwives, some of the midwives and considering all of the midwives and the data that I was working with. The experiences of the midwives differed but also merged to some understanding which could be organised into themes. In seeking to understand the dialogue of the midwives, I became aware of the hermeneutic circle and many of own pre-suppositions seemed irrelevant and were set aside.

As stated, I stayed away from the labour ward when the new hospital opened as I did not want to have preconceptions of the midwives as they worked. I was aware of the



stressors for all staff as they moved through the transition and amalgamation of maternity services.

In Chapter 8, I described my experience as I met with midwives in the new unit and undertook the initial interviews. I did not decide how many midwives I would interview but each midwife brought new perspectives on their experiences. Their many shared issues were not difficult to identify, but differences were also apparent, and this was reflected in the initial coding of the data. The challenge was to separate out the data. This eventually emerged as the themes for this study and the paradox discussed in the last two chapters which identified that, in this unit, there were many opportunities for women to experience optimal and possibly beautiful births. That these could be enacted in the midst of a busy and technocratic labour ward was surprising.

While I am aware that the seventeen midwives I interviewed are not representative of all the midwives working in this labour ward at the time, I also have some evidence that the experiences and practices described here are still present in the unit. This comes from my continued link to the service and is reflected back to me both from the student midwives who occasionally experience this type of birth, and also my encounters with some women who have experienced optimal births in the unit.

I hope that this brief reflection of my journey through this study explains my attempt to be as open as possible regarding the data and to minimize the risk of including my polarised versions of midwifery care with preconceived biases of labour ward midwifery practice. I was also influenced by the discussions and debates I had with my supervisors who repeatedly questioned and challenged my judgements causing me to repeatedly reflect and engage with the data until I reached the understanding presented in this thesis. The next chapter provides a conclusion to this work.

## CHAPTER 17 EXPLAINING THE PARADOX – NORMAL RULES DON'T APPLY

### **Introduction**

This study was undertaken to explore labour ward midwives' construction of childbirth as they negotiate ways of facilitating birth in a hospital labour ward. The context of the study was a maternity hospital which was due to close and merge services with two other units into a large new hospital. This provided the opportunity to explore with the labour ward midwives their experience of midwifery in their existing environment and again following the move to a larger unit. I hoped that this would uncover the essential meaning of midwifery as the midwives adjusted their practice to their new setting. I did not anticipate that their experience in the new maternity hospital would include such changes in their mode of working.

As stated earlier, I was initially interested to know how midwifery practice was perceived, how innovations were adopted or resisted, and how birth practices were disseminated among the midwives. Through exploring the experience of midwives in the context of their everyday practice, I hoped to gain an understanding of how they facilitated birth and whether they were instrumental in normalising births in such a large obstetric led hospital.

In the initial interviews it appeared that the management of labour was largely routinised following a biomedical approach to care with a range of technologies and interventions expected to be used. The midwives maintained that they wished to provide 'real' midwifery, yet practised as if bound by the power dynamics in the maternity unit which worked against them achieving this. There was an acceptance among them, that maternity care was based on medical protocols and emerging technologies, and as a consequence intervention was accepted as a 'normal' part of birth. Cognitive dissonance was apparent as the midwives spoke about their work and consonance was largely achieved, by midwives' acquiescence with the norms of the unit and not accepting any responsibility for the levels of intervention or type of care provided. In keeping with a philosophy of supporting 'normal birth' they occasionally provided 'real midwifery' for individual women. Positive births occurred as chance events or could be enacted by midwives if the opportunity arose.

These births were described by midwives as lucky events for the women involved.

In the first phase of the study, the midwives felt disempowered, and sometimes frustrated. This was considered in terms of Lipsky's (2010) street level bureaucrats with the additional consideration of the phenomena of damaged identities (Lindemann Nelson 2001). The midwives worked under the surveillance of the Foucauldian Panopticon and self-regulated their behaviour in the expectation that they were being overlooked.

In the new hospital the power dynamics had changed. The midwives had come from the order and stability of three long established maternity units where change was slow and innovation, at least in Hospital A, resisted. They experienced a change in their environment which led to the chaos experienced with the opening in the new hospital. The priority throughout this period was the provision of one-to-one care, and this was maintained as the workload of the unit and throughput of women required this for the safety for the women and their babies. The scarcity of labour rooms also ensured that there were an adequate number of midwives on each shift so that this level of care could be provided. Of necessity, systems and practices took shape and new norms became established. A new order emerged as the midwives engaged with their environment.

The findings revealed a paradox of this mega maternity unit, whereby due to the increased workload of all staff the labour ward midwives escaped from the Foucauldian Panopticon of obstetric and midwifery surveillance. Due to the size of the unit there was no longer a consensus approach to the management of women in labour. While obstetric practices were normalised in the unit, several midwives found ways around this. They developed ways to resist obstetric norms, and found strategies to manage both space and time in childbirth, not often recognised in hospital settings. In providing one-to-one care midwives, stayed within the labour room and worked in relative isolation. If all was straightforward, the midwife and woman were largely uninterrupted. Issues of autonomy and authenticity emerged as midwives provided individualised care through discussion or negotiation. The escape from the Panopticon enabled them to practice in new ways. Optimal birth experiences were no longer chance events.

The midwives' experience of caring for women in labour in the space of the new labour rooms was revealed through the four existentials of Merleau-Ponty (1962). As discussed in Chapter 15, time had a new meaning; midwives kept track of labour progress in linear time but could create a sense of timelessness for the woman to labour and give birth. There was no pressure for labour to be rushed and I was repeatedly told that *labour takes time*.

The discourse of the midwives revealed that their relationships with women had changed. In the earlier interviews, women appeared passive and the midwives were largely instrumental in the care provided. The relationship that emerged from providing one to one care, in the absence of interference, seemed to have enacted a responsibility in the midwife to obtain, for the woman, an optimal experience of the birth. Decisions were shared and strategies negotiated, if possible avoiding recourse to epidurals to manage the woman's painful contractions. Where trust and reciprocity could be established, this was valued by the midwives. Midwives negotiated and suggested strategies to help women to cope with their labour, or alternatively remained quiet and respectful of the space. In contrast to the earlier interviews, the midwives demonstrated a greater emotional investment in the outcome of a woman's labour and birth.

In relation to the space of the labour room, neither the midwives nor the women in labour moved outside. Women were cocooned in this space, privacy maintained and any interference encountered was stridently rebuffed. Within the space of the room, full of equipment and supplies, midwives had opportunities to optimise the birth experience using a range of strategies appropriate to the woman's needs. They varied in the strategies used but alternatives, which had previously been ridiculed, were now an accepted part of midwives' repertoire. The midwife's knowledge and sense of being with women in birth, had enabled nascent midwifery practices to emerge.

In terms of embodiment, the midwives no longer provided a standardised approach to care and were largely unaware of how other midwives practiced. A consequence of this was that they now had to confront their own approach and beliefs about childbirth. In comparison to the earlier interviews, there was an increased awareness among the midwives that they were instrumental in the woman's experience of the

birth and while protocols were largely followed, midwives were more woman-centred in their approach than before. Through embodied ways of knowing, they were attentive to the diversity of individual women's needs, they were cognisant that women had better experiences of birth with less intervention in their labour. They had freedom to enact embodied ways of knowing and interpreted hospital guidelines flexibly. Some avoided vaginal examinations and many used strategies to delay or avoid requests for epidurals. Midwives had opportunities to orchestrate positive births (Kennedy et al. 2004), and, though these births were not recognised or valued in the unit, the midwives shared, with the women, the joy and achievement of the birth. This was reflected in the language midwives used. Positive birth experiences were no longer described as rare or *lucky* events. The feedback midwives received from this type of birth was reaffirming and sustained their belief in seeking to repeat these events. Thus, when opportunities arose, midwives enacted 'real midwifery', an approach to care which had become self-perpetuating. The autonomy midwives experienced was restorative and had gone some way to restore their 'damaged identities' and gave value to their work.

The implications of this study are that, when midwives have freedom and autonomy to practice a woman-centred approach to care, they practise according to the core philosophy of midwifery; this leads to greater satisfaction for the midwife, both physically and emotionally. Where midwives accept the uncertainty and complexity of childbirth and enact 'real' midwifery this may lead to the generation of wellbeing (salutogenesis) for new mothers (Downe and McCourt 2008). The generation of wellbeing was apparent in many of the birth stories recounted; midwives shared with women in the joy of a potentially empowering birth, particularly when this occurred without intervention.

### **Recommendations**

To conclude this work it is worth highlighting the aspects of this study that are relevant to midwifery education, midwifery practice, the organisation of maternity care and areas for further research.

In relation to education, the midwife in education is required to prepare midwives with the skills and competencies to provide safe and effective care to women and

their families. A challenge for educators is to prepare students for the realities of practice, particularly where they may obtain employment in busy hospital labour wards. The philosophy of midwifery in 'normal childbirth' is a key component to midwifery education programmes (An Bord Altranais 2005, ICM 2011). Despite this, acquiring the knowledge, attitudes and skills in normalising birth is difficult for students when most or all of their only experience of childbirth is in technocratic hospital settings. When experiencing clinical practice, students should be encouraged to identify midwifery role models, where the midwife provides a woman centred approach to care. Midwife educators should also maximise opportunities for students to experience maternity care in out of hospital settings and, students encouraged to broaden their experience when qualified and seek practice experiences in alternative settings.

In terms of midwifery practice, qualified midwives should be encouraged to share their expertise and their positive birth stories with students and, both midwifery and obstetric colleagues. In this way the skills for obtaining an optimal birth can be disseminated. In addition, midwives should be supported and facilitated to undertake on-going education programmes to develop the knowledge and skills required to facilitate normal birth.

Ideally, continuity of carer would be provided for all women as a standard of care. This can be difficult to achieve in all settings, and will not meet the requirements of women who may require a range of health care practitioners. Where a fragmented service is provided, midwives who meet women in the antenatal period should have the skills to prepare women for the realities of labour and the value in giving birth with minimal intervention. Labour ward midwives require skills to establish reciprocal relationships, the confidence to, support women through the pain of labour, skills to optimise the woman's birth experience, and how to normalise birth where intervention is required. Midwives in a postnatal area should find time to listen to women's account of their birth and in hearing their stories, provide positive affirming support.

In relation to the organisation of care within the labour ward, the provision of autonomous one to one care was a key factor for the midwives in this study to change their practice; this was often in response to the needs of individual women.

Women centred care became possible by the absence of surveillance and an understanding that unwarranted interference was no longer acceptable. Safe care requires skilled competent midwives and support must be provided for junior midwives to develop appropriate skills. Nevertheless, the midwives' contribution towards normalising birth should be recognised as means, not just to optimise the birth experience for women, but as a strategy to reduce unnecessary intervention.

Finally, following the completion of this study, there are two recommendations for further research in this area. It would be interesting to undertake a follow up study of women who have had positive, affirming births as identified by midwives. What was their experience of the labour and birth? What was important to them in terms of their midwifery care? It would also be interesting to consider the factors in other large maternity units which can contribute to optimal births. One to one care, an absence of surveillance, and midwifery autonomy were factors in this study which enabled the midwives to effect optimal births. Further research could identify if the factors identified here also exist in other large units.

To conclude, this study reflects the complexity of midwives' experiences of labour ward midwifery in a technocratic environment of a large tertiary level maternity hospital. It is hoped that the findings from this study will have implications for the kind of maternity care being delivered in publicly funded labour wards.

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# Appendices

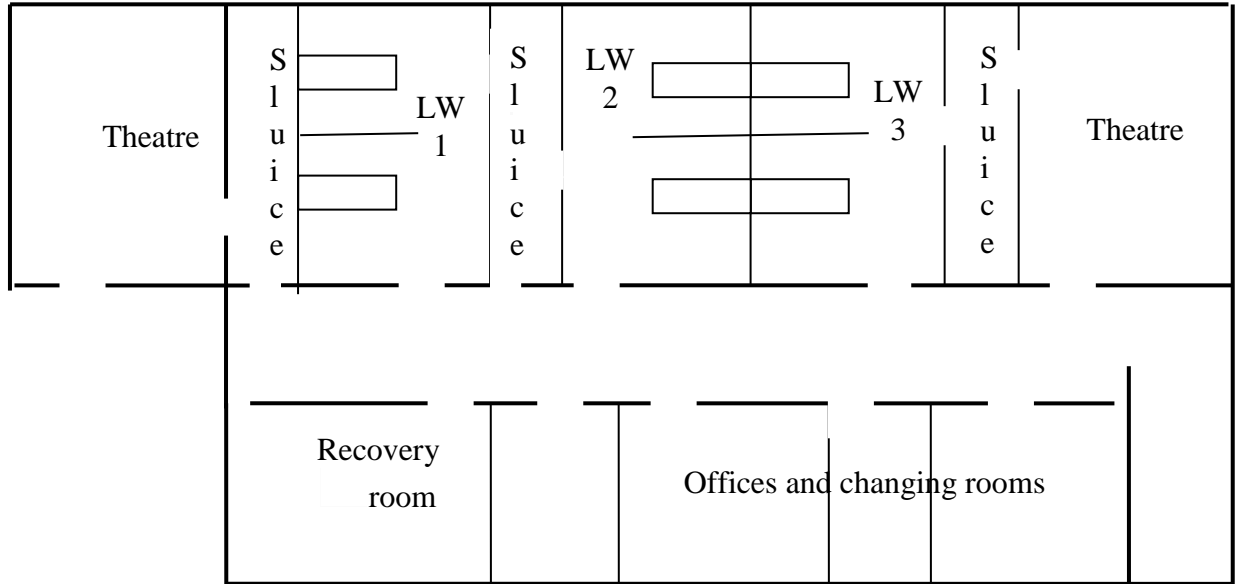
## Appendix 1 Characteristics of included studies

Criteria	Hunt and Symonds 1995 Wales	Kirkham 1999 England	Shallow 2001a-d England	Hunter M. 2003 NZ	Hyde and Roche-Reid 2003 Ireland	Lavender & Chapple 2004 England	Hunter B. 2004, 2005 Wales
Scope and purpose	Activities and social processes at work in Labour Ward (LW) setting.	Culture of midwifery, context of practice	Midwives experiences of becoming integrated and working in a team.	Midwives' differences in intrapartum care in small and large hospitals	Midwives' perception of their role and their views on active management of labour	Midwives views about birth settings, models and philosophy of care	Midwives experience and management of emotion in their work
Design	Ethnography  Observation Interviews	Ethnographic approach  Interviews	Mishler's feminist approach Interviews	Qualitative descriptive.  Interviews	Habermas' theory of communicative action Interviews	Social constructionist Appreciative Inquiry. Focus group interviews	Ethnography Focus group, individual interviews Observation
Sample	2 maternity units	168 midwives  5 sites	6 team midwives	10 independent midwives	12 LW midwives  3 hospitals	Focus groups (15) Midwives (120) Students (6) 14 sites	Students (27), midwives (28) Focus groups, observation and interviews (12)
Analysis	Progressive focussing to identify themes	Grounded theory	Modified grounded theory with feminist ideology	Van Manen's hermeneutic analysis.	Grounded theory style, constant comparison.	Themes identified, consensus agreed.	Themes analysed, mind mapping
Interpretation	Quotations, field notes, drawings	Parallel process, oppression, gendered institution	Largely descriptive	Largely descriptive	Relates to 'tensions of modernity	Summaries returned to members of groups	Contrasts practice in home and hospital
Reflexivity	Apparent	Not apparent	Some reflection	Not apparent	Not apparent	Not apparent	Search for trustworthiness of the data. Peer validation
Ethical issues	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed
Relevance /transferability	LW midwives	Yes	Contrasts hospital and community	Contrasts care in small and large units	LW midwives	Yes	Emotional labour. Mostly junior midwives

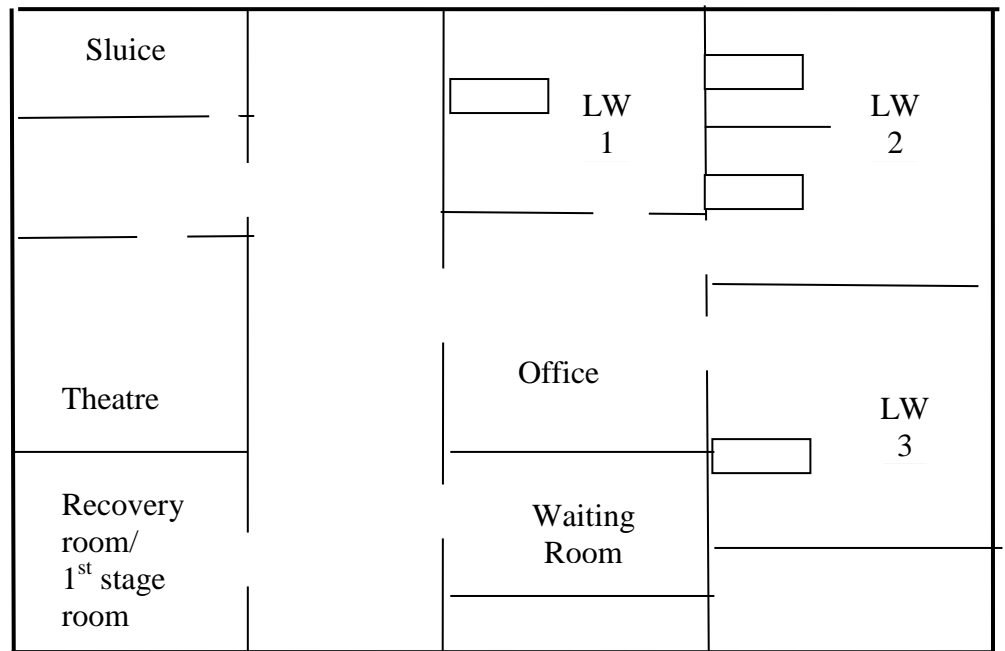
<b>Criteria</b>	<b>Crabtree 2004 NZ</b>	<b>Earl and Hunter 2006 NZ</b>	<b>Davies and Iredale 2006 Wales</b>	<b>Porter et al. 2007 England</b>	<b>Russell 2007 England</b>	<b>Blaaka and Schauer 2008 Norway</b>	<b>Keating &amp; Fleming 2009 Ireland</b>
Scope and purpose	Midwives' construction of 'normal birth' and influences on this	Experience of midwives in tertiary hospitals in 'keeping birth normal'	Midwives perception of their role and influences on their practice	Midwives' decision-making strategies relating to the use of technology	Midwives' experiences of supporting normal birth	Midwives experience of biomedical and a phenomenological belief system	Midwives' experiences of supporting normal birth in an obstetric-led unit
Design	Qualitative descriptive with feminist underpinning Interviews	Qualitative interpretative  Interviews	Focus group methodology  Interviews (7)	Qualitative descriptive  Observation Focus group interview	Grounded theory  Interviews	Phenomenological approach  Interviews	Feminist approach  Interviews
Sample	9 independent midwives	8 core midwives  2 tertiary hospitals	48 midwives	2 hospitals, Observation (n = 16), Focus group (n = 8)	6 LW midwives, from 2 obstetric led units, who attended a 'normal birth workshop'	7 experienced midwives high technology LW	Purposive sample 10 LW midwives, 3 maternity units
Analysis	Thematic analysis	Van Manen used	Thematic analysis	Constant comparison Data saturation achieved	Strauss and Corbin used	Giorgi used	Words, phrases and meanings identified, themes developed
Interpretation	Interpretive	Largely descriptive	Descriptive analysis.	New professionalism Largely descriptive Explanation of modes.	Interpretive	Interpretive	Warren's concept of patriarchy used to interpret themes
Reflexivity	Apparent	Not apparent	Not apparent	Not apparent	Not apparent	Not apparent	Apparent
Ethical issues	Not addressed	Addressed	Addressed	Addressed	Addressed	Addressed	Addressed
Relevance /transferability	Independent midwives who attend hospital births	Yes	Yes	Yes	Experienced LW midwives interested in normal birth	Experienced LW midwives	Experienced LW midwives interested in normal birth

## Appendix 2 Plan of labour wards for three hospitals

### Hospital A\*



### Hospital B\*



\*Drawings are approximate and not to scale

# Hospital D

## Ground Floor (detail)



## Appendix 3 Ethical approval letters



UCC

Tel: + 353-21-432 1563  
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Coláiste na hOllscoile Corcaigh, Éire  
**University College Cork, Ireland**

COISTE EITICE UM THAIGHDE CLINICIÚIL  
**Clinical Research Ethics Committee**

Lancaster Hall  
6 Little Hanover Street  
Cork  
Ireland

ECM 3 (ff) 07/03/06

21<sup>st</sup> February 2006

Ms Rhona O'Connell

**Re: Midwives construction of childbirth in a technocratic hospital environment in Ireland.**

Dear Ms O'Connell

Expedited approval has been granted for the above Study.

Yours sincerely

Dr Michael Hyland  
Chairman  
Clinical Research Ethics Committee  
of the Cork Teaching Hospitals

24/02/06

Soo Downe  
Midwifery  
University of Central Lancashire

Dear Soo,

**Re: Faculty of Health Ethics Committee (FHEC) Application – CA 035**

The FHEC has granted approval of your proposal application “Midwives Construction of Childbirth in a Technocratic Hospital Environment in Ireland” on the basis described in its ‘Notes for Applicants’.

Recommendations

1. Although it appears from the ethics application form that it is not usual practice in Cork to require researchers to submit an information sheet for research such as this, it is normal UCLan practice to require approval of such documentation. Whilst, in this instance, we shall not withhold approval given the external REC's approval, we would welcome the submission of an Information Sheet and the opportunity to comment on and approve this documentation.
2. Likewise, we would welcome the submission of the interview schedule, for our records.
3. Data storage is covered rather briefly. We would appreciate confirmation that data, particularly the tapes prior to anonymisation of their content and the Consent Forms, will be stored (securely, as stated) on one of the research 'sites' and details of where this will be. Additionally, details regarding the duration of storage of the data, particularly the original tapes, should ideally be provided. It is worth noting that the UCLan Code of Conduct for Research states that "All primary data as the basis for publications should be securely stored for at least ten years in a paper and/or electronic form, as appropriate, after the completion of a research project."

Yours sincerely

Chris Sutton  
Chair  
**Faculty of Health Ethics Committee**

CC: Rhona O'Connell



18/07/2006

Rhona O'Connell  
Midwifery  
University of Central Lancashire

Dear Rhona,

**Re: Faculty of Health Ethics Committee (FHEC) Application – CA 035**

The FHEC has granted approval of the proposed amendments to your previously-approved project titled 'Midwives Construction of Childbirth in a Technocratic Hospital Environment in Ireland' on the basis described in its 'Notes for Applicants'.

Yours sincerely

Chris Sutton  
Chair  
**Faculty of Health Ethics Committee**

Cfi:            Soo Downe



UCC

Tel: + 353-21-490 1901  
Fax: + 353-21-490 1919

COISTE EITICE UM THAIGHDE CLINICIÚIL  
**Clinical Research Ethics Committee**

Lancaster Hall,  
6 Little Hanover Street,  
Cork,  
Ireland.

Coláiste na hOllscoile Corcaigh, Éire  
**University College Cork, Ireland**

Our Ref: ECM 4 (a) 05/02/08

11<sup>th</sup> December 2007

Ms Rhona O'Connell

C  
S  
B  
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**Re: Midwives construction of childbirth in a hospital environment in Ireland.**

Dear Ms O'Connell

Expedited Approval is granted to carry out the above study at the following site:

➤ Cork L

Yours sincerely

Dr Michael Hyland  
Chairman  
Clinical Research Ethics Committee  
of the Cork Teaching Hospitals

7<sup>th</sup> April 2008

Rhona O'Connell/Soo Downe/Fiona Dykes/P O'Donovan  
Midwifery  
University of Central Lancashire

Dear Rhona, Soo, Fiona & Pat

**Re: Faculty of Health Ethics Committee (FHEC) Application – (CA 109)**

The FHEC has granted approval of your proposal application 'Midwives construction of childbirth in a technocratic hospital environment in Ireland' on the basis described in its 'Notes for Applicants'.

We shall e-mail you a copy of the end-of-project report form to complete within a month of the anticipated date of project completion you specified on your application form. This should be completed, within 3 months, to complete the ethics governance procedures or, alternatively, an amended end-of-project date forwarded to Research Office.

Please also note that it is the responsibility of the applicant to ensure that the ethics committee that has already approved this application is either run under the auspices of the National Research Ethics Service or is a fully constituted ethics committee, including at least one member independent of the organisation or professional group.

Yours sincerely

Chris Sutton  
Chair  
**Faculty of Health Ethics Committee**

## Appendix 4 Notice for midwives Phase I

### **Calling all labour ward midwives**

#### **Invitation to participate in a midwifery study**

I am a midwife lecturer, currently undertaking a PhD degree at the University of Central Lancashire. As part of this programme I am undertaking research on midwives experience of hospital birth.

If you have at least 6 months experience in the labour ward and work a minimum of 24 hours per week I would be delighted if you could give me some of your time.

If you agree I would like to interview you about your midwifery experiences. The interview will be for probably less than an hour and will take place at a time and place suitable for you. The entire process will be treated in the strictest confidence and your anonymity will be guaranteed.

This research has received ethical approval from Clinical Research Ethics Committee and the Division of Obstetrics and Gynaecology for the (name of maternity hospital). It is being supervised by Professor Soo Downe, Department of Midwifery Studies, UCLan in Preston.

If you are interested in being part of this study or would like some further information contact me at xxxxxx.

Thank you in anticipation of your cooperation and I look forward to hearing from you

Rhona O'Connell

## Appendix 5 Information for midwives Phase I

### **INFORMATION LEAFLET FOR LABOUR WARD MIDWIVES**

**This leaflet is to provide you with information about a study I am undertaking to explore labour ward midwives' experience of midwifery in a hospital setting.**

I am a midwifery lecturer in the School of Nursing and Midwifery, UCC and am registered as a PhD student with the Department of Midwifery Studies, University of Central Lancashire in Preston; this study is part of my PhD.

#### **What is this study about?**

This study aims to explore the experiences of midwives working in a labour ward. This has not been undertaken in Ireland before now.

#### **What is involved if I agree to partake in this study?**

I would like to interview you about your midwifery experiences. The interview will take about 30 – 45 minutes during which I ask you a few questions about what midwifery means to you. The interviews will be undertaken at a time and place that is convenient for you. With your permission, I will use a tape recorder to help me to recall the interview accurately.

#### **Will the information I provide be anonymous and confidential?**

Every precaution will be provided to respect your privacy. The information you provide will remain anonymous and confidential. Your identity or where you work will not be revealed by me at any stage. At the start of the interview you will be given the opportunity to select a fictitious name which I will use in writing up the findings. The tape recordings used during the interview will be erased and the transcriptions will not contain any personal information which could identify you or the hospital.

#### **Who else will take part in the study?**

I will be conducting interviews with midwives in a number of hospitals. When the findings of the study are written up, the data from the midwives will not be linked to any of the units.

#### **What are the benefits of the study?**

The study seeks to identify the experiences of midwives in the labour ward and the influence this has on practice.

#### **Do I have to take part in this study?**

There is no obligation on you to take part in the study. Even if you agree to take part initially, you have the right to withdraw at any stage.

#### **Does the researcher have permission to carry out this study?**

Yes, I have permission from the Director of Midwifery, the Division of Obstetrics, Gynaecology and Neonatology and I have also received ethical approval for this study from the Clinical Research Ethics Committee of the Cork Teaching Hospitals and the Faculty of Health Ethics Committee of the University of Central Lancashire.

**Rhona O'Connell**

phone xxxx (work) xxxx (mobile)

## Appendix 6 Consent form Phase I

### Consent Form

**Study:**

**Labour Ward Midwives' Construction of Childbirth**

I consent to be interviewed by Rhona O'Connell. I understand that this interview will be tape recorded and subsequently transcribed.

I have been informed that the information I provide will remain anonymous and confidential and I have been given the opportunity to select a fictitious name which will be used in writing up the findings.

I have also been informed that the tape recordings used during the interview will be erased and the transcriptions will not contain any personal information which could identify me or the hospital.

Signed: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_

**Original for participant**

## Appendix 7 Biographical details of midwives interviewed

### Phase I

#### 1. Sarah works 24 hours (2 shifts per week)

**1<sup>st</sup> interview** - 24 years midwifery experience, all in Hospital A with the majority of this time in the labour ward. Qualified as a midwife from Hospital A and had not worked elsewhere.

#### **Reflections following interview:**

*My sense of this interview was that for Sarah, the medical system and concerns about potential litigation were dominant in how she could think about midwifery. While she is confident and experienced in her own practice, she does not question the authority of doctors. She recognises differences between midwives but does not criticise the practice of others. She has an understanding of what can be good midwifery care but does not feel that it can be delivered unless away from medical interference. She was mildly irritated if another midwife interfered with her care or if an anaesthetist came into the room to offer a woman an epidural when it had not been requested.*

#### 2. Marie works 24 hours (2 shifts per week)

12 years midwifery experience, the last 8 of these were spent in the labour ward of Hospital A. Qualified as a midwife from Hospital A and Hospital B (shared programme). Marie did not transfer to the labour ward in Hospital D and therefore was not interviewed again.

#### **Reflections following interview:**

*My sense of this was that Marie had genuine(authentic) empathy for the women were experiencing in labour and tried to do her best for them, perhaps without that being recognised much by the women or the other midwives. The busyness of the unit and the numbers of inductions etc appeared to impact on the care that she provided. She valued the team approach, everyone working together to ensure good outcomes. Her relationship with the woman in labour was important to her. While I knew this midwife for many years the depth of her feeling for the women and the genuineness of her account was not something I expected.*

#### 3. Jennifer works 24 hours (2 shifts per week)

15 years midwifery experience the last 8 of these spent in the labour ward. Qualified as a midwife in Scotland. Jennifer did not wish to be interviewed in Hospital D though she continues to work in the labour ward.

#### **Reflections following interview:**

*Jennifer was willing to be interviewed (maybe to oblige me) but appeared somewhat uncomfortable talking on tape. When I worked with her many years ago in clinical practice, I remember her being dissatisfied with midwifery practice in Ireland compared to her experience in Scotland. Possibly this was in her mind too when she was talking to me. When the tape was turned off she spoke more freely, asking me about what I thought about these issues and the difficulties LW midwives experience, I suggested that probably if I was back working there I would also comply with what goes on.*

*She also told me of a story of a woman in spontaneous labour who requested an epidural but was encouraged to hold off and was delighted when she gave birth without it. Another woman was 'sent up' by a doctor 'for an epidural', Jennifer stated that she will discuss the necessity for whatever intervention with a registrar but not with the consultant who may 'send a woman up for an ARM and Syntocinon after 2hrs if no progress'. This is common. It appears the midwives in this setting are very adaptable- meeting the needs of women where they can but also having to consider the needs of the unit, how busy it may be at the time and the doctors. Private practice makes a difference.*

#### **4. Amelia works 36 hours (full time)**

**1<sup>st</sup> interview** - 4 years midwifery experience mostly in the labour ward of Hospital A. Qualified as a midwife from Hospital A + Hospital B. Considered herself to be a junior midwife on the unit.

##### **Reflections following interview:**

*Amelia spoke very freely and impressed me with her leaning about birth, I felt that she will continue to develop her skills. I was sorry I finished the interview when I did, I should have asked more questions about what strategies she has tried out that has worked, how she has developed her skills, is it from the women or her own confidence in birth?*

#### **5. Margaret works 36 hours (full time)**

**1<sup>st</sup> interview** - 15 years midwifery experience which included 12 years working in the labour ward of Hospital A. Margaret trained as a midwife in UK and worked as a midwife in London and the Middle East before returning to work in Ireland.

##### **Reflections following interview:**

*Margaret spoke freely and comfortably about her practice, she stated afterwards that you could have a period with a run of normal deliveries and then you would not have any for a while. She is the first midwife interviewed who appears to have the confidence and skills to help women to achieve a normal labour. She encouraged mobilisation despite the presence of two beds in each room with possibly another woman in labour. She tries to help women through their labour by delaying interventions ARMs, and epidurals, we did not talk about Syntocinon, her strategy is to get women to move around. She has no difficulties with the other doctors or midwives and seems to be able to practice with a degree of autonomy.*

#### **6. Sandy works 36 hours (full time)**

**1<sup>st</sup> interview** - 7 years midwifery experience, 4 years working in the labour ward of Hospital A. Qualified as a midwife in London and worked both there and in Australia before returning to Ireland.

##### **Reflections following interview:**

*What happens at the point of interaction – it could go one way or another? Midwife stays labour progresses, that midwife or other midwife changes and all turns out differently. Complex interaction/dynamics – woman/midwife others around*



*Sandy goes with what the woman wants and is generally dissatisfied with the model of maternity care. Feels that there is little that she can do about it and complains about it to like-minded colleagues. Can be confrontational.*

## **Phase II**

### **1. Patricia works 36 hours (full time)**

20 years midwifery experience. Qualified as a midwife in Scotland, worked in Canada, Australia and London prior to returning to Ireland. Worked as a LW midwife for 13 years in Hospital B prior to transfer to the new hospital.

#### **Reflections following interview:**

*During the interview, this midwife spoke with little prompting, she appeared to be very confident, competent. She maintained that her UK training influenced her approach to being less interventionist and she was supported when she started work in the 'low intervention unit Hospital B'. During the interview I felt I had an insight into her practice, she did not seem to be influenced by others to intervene unnecessarily. She stated that she preferred to care for women without intervention, this was more of a challenge for her than caring for women who have induced labours or epidurals. She did not use the term 'real midwifery', though this appeared to be her preference. I should have probed deeper, probably the initial discussion on Australia and Canada was unnecessary though at the time I was wondering how this impacted on her practice.*

### **2. Rose works 36 hours (full time)**

18 months midwifery experience. Qualified as a midwife from Hospital A + Hospital B, employed in LW of Hospital B prior to transferring to the new hospital.

#### **Reflections following interview:**

*Used non medicalised language throughout. This midwife was interviewed just before she commenced maternity leave. I was unsure whether it was appropriate to ask her about her own hopes for her labour; in the end I avoided this topic. When I met her on the unit she was smiling, another midwife commented that 'she is always smiling', she appears to be happy in her work. She brought hand written notes to the interview, which she said was some statistics for the unit. After the interview I felt a certain frustration that she offered no complaints and wondered if she was not prepared to say anything negative about her colleagues - maybe from a loyalty to them or to the service?*

### **3. Ann works reduced hours 30 hours (2.5 shifts/week)**

8 years midwifery experience, qualified as a midwife from Hospital A + Hospital B, employed in LW of Hospital B prior to transferring to the new hospital.

#### **Reflections following interview:**

*When I met this midwife on the unit, she was immediately willing to be interviewed but mentioned a child minding issue. I appreciated that expecting midwives to meet me when off duty was not fair on them and if possible I should try and conduct some interviews during work hours. This would be difficult due to the busyness of the unit. This midwife was working on a Sunday so I asked her to let me know if it was quiet*

*and I could be there in 30 mins. I received a text message at 08.30 and managed to interview this midwife and two others that morning. Going from one interview to the next was difficult as it did not give me a chance to reflect on the interview. These 3 interviews took place in the 'home from home room'. We were not disturbed.*

*Other midwives had respect for Ann's practice, this was reflected by Edel who commented that she had learnt a lot from working with her in Hospital B. It was not easy to get her to expand on her answers, I regret not focusing more on birth stories - might have been more productive.*

#### **4. Edel works 36 hours (full time)**

18 months midwifery experience, qualified as a midwife from Hospital A + Hospital B, employed in LW of Hospital B prior to transferring to the new hospital.

#### **Reflections following interview:**

*This was directly after the last interview, the midwife is a recent student, Edel was 18 months qualified yet had a lot of confidence, she developed skills on normalising birth in Hospital B and had adapted well to the new unit where it had been forgotten that she had limited experience. She spoke freely and had regard for the midwife previously interviewed. She spoke of the beauty of birth*

#### **5. Meg works 36 hours (full time)**

21 years midwifery experience, qualified as a midwife in the UK worked as a community midwife for 19 years and on Sure Start programme. Worked in Hospital A for 6 months prior to the transfer. Stated that maternity care in Ireland is more medicalised than her experience in UK and private care also makes a difference. Doctors are more involved with women in labour.

#### **Reflections following interview:**

*This midwife has adapted to her environment, from UK to Ireland and can see differences but these are not problematic, more medicalised here 'doctor' calls the shots, use of CTG and resuscitaire, vaginal examinations. I should have probed more, I did not get any birth stories, just impressions. This was the third interview in short succession and was more difficult for that reason - it was opportunistic, on a quiet Sunday morning.*

*Inductions, epidurals, monitoring, progress important 'ARM and Synt' - this was also my observation at the desk when waiting to meet the midwives. Midwives were in and out of rooms to write on the white board, use phones, complete birth register. Monitoring is pervasive.*

*Following these five interviews I was beginning to get a feel for the experience of the midwives working in the unit. The isolation and lack of support and also the impact this had on the midwives who were working alone.*

#### **6. Sandy works 36 hours (full time)**

**2<sup>nd</sup> interview** - Second interview with this midwife, she has since left the LW to a non-clinical role in the maternity hospital.

**Reflections following interview:**

*This midwife appears more contented than when previously interviewed. She values the greater autonomy but is impacted by the busyness of the unit. She sees midwives in two categories, those that work for the 'team' and those that work for the 'women'. Not sure how Street Level Bureaucracy works in the new unit. The workload impacts on everyone - more autonomy and less interference for individual midwives, but also maybe less support - need to follow up on this*

**7. Mary works 36 hours (full time)**

8 months midwifery experience. Qualified as a midwife Hospital A + Hospital B and completed her midwifery education programme in Hospital D. Commenced working as a qualified midwife in clinics and requested a transfer to LW. Was working in the LW for 6 months at the time of the interview.

**Reflections following interview:**

*Very enthusiastic about working in the unit and gaining experience, contradictions – 'its dreadful' and 'its brilliant', seems to thrive on the challenge. Woman largely objectified but developing skills in managing the birth but some nice touches. Talks about reflection and, learning from practice. Managing between bio medical and more holistic approach - towards the natural 'just know which ones' judges each woman differently, learning from personal reflection rather than working and observing other midwives.*

**8. Sarah works 24 hrs (2 shifts per week)**

**2<sup>nd</sup> Interview** - 26 years midwifery experience, all in Hospital A and most of this time was in the labour ward. Qualified as a midwife from Hospital A and has not worked elsewhere

**Reflections following interview:**

*Every conversation comes back to the medical aspects of childbirth. Seems more on the medical side with each conversation - respect, kindness to the woman. Evidence of learning 'you would hear it', pick things up yet unlike the other midwives she did not seem to be using the resources available – use of shower, ball etc.*

**9. Sheila works 36 hours (full time)**

18 months midwifery experience. Qualified as a midwife from Hospital A + Hospital B and worked in the labour ward of Hospital B.

**10. Susan works part time 24 hours (2 shifts per week)**

23 years midwifery experience. Qualified as a midwife from Hospital A where she had worked mostly in LW before transferring to new hospital.

**Reflections following interview:**

*I know this midwife a long time and she had always impressed me as being woman centred in her approach to midwifery - happy to be back giving direct care to women rather than being 'on charge' in Hospital A, missed opportunities to discuss aspects of care with other midwives.*

**11. Elaine 36 hours (full time)**

18 months midwifery experience. Trained as a midwife in Dublin and worked there for 6 months before moving to Hospital C when it opened. Has spent 6 months in the LW at the time of the interview.

**Reflections following interview:**

*Was adjusting to moving away from Active Management of Labour where decisions were made after the woman was 12 hours in labour. Maintained that Hospital D was also very medicalised but also stated that she had never previously witnessed SROM in labour.*

**12. Claire works 36 hours (full time)**

12 years midwifery experience. Qualified as a midwife from Hospital A + Hospital B. Worked in a large maternity hospital in the Middle East for 1 year before returning to Hospital B, worked in a variety of areas but mainly in LW prior to transfer to new hospital.

**Reflections following interview:**

*Sees herself in a senior role, supporting the midwifery manager and responding to assist midwives rather than taking a woman herself. More aware of the bed management issues than the other midwives interviewed*

**13. Barbara works part time 24 hours (2 shifts per week)**

14 years midwifery experience. Qualified as a midwife from Hospital A + Hospital B. Worked mainly on night duty in LW for 10 years prior to transfer to new hospital. Has since left the maternity service to work in another area of practice.

**Reflections following interview:**

*Was looking forward to interview this midwife because I was aware that she supported 'normal birth', she was one of a few midwives who was pleased that other midwives recognised this and she would often take the women who wanted a 'normal' birth. She was the only midwife interviewed who avoided working in the Induction Room.*

**14. Amelia works 36 hours (full time)**

**2<sup>nd</sup> interview** - Qualified as a midwife from Hospital A + Hospital B x years. Worked as LW midwife in Hospital A prior to transfer.

**Reflections following interview:**

*Amelia appeared much more confident than when I had interviewed her before the move. This confidence was reflected in all the interviews and may have been due to their working in isolation and being responsible for the care that they provided. There was no choice in this for any of the midwives*

**15. Margaret works 36 hours (full time)**

**2<sup>nd</sup> interview** - Since the opening of the new hospital Margaret works between labour ward and theatre.

**Reflections following interview:**

*I lost some of this interview as the tape had switched off without me being aware of it. The discussion continued about junior midwives. She enjoys the work in the LW, relationship with woman important, her experience developed over time, finds what works, individual care. Doctors come in when they do their rounds but will go away if you say the woman is giving birth. Some knock but others come in, the curtain provides privacy. This is the biggest advantage of the unit. Mostly the midwife can stay with the woman. Midwives do pick up ideas from each other despite little time for having a chat. The balls and use of positions are examples she gave.*

*This midwife seems to keep matters to her self - does her own work. In comparison with other midwives, some are more aware of what is happening around them and may have more concerns as a result.*

*Neither subversive nor discursive but she keeps quiet, in her own bubble, has confidence to work autonomously. This is also what I picked up on my previous interview with her, she appears self-contained and self-reliant.*

**16. Michele works part time 30 hours (2.5 shifts per week)**

8 years midwifery experience, qualified as a midwife from Hospital A + Hospital B. Working in Hospital B prior to transfer but was on maternity leave during the amalgamation of the services. Returned to work 6 months after the opening of the new hospital.

**Reflections following interview:**

*Importance of checking equipment so that if needed it is ready at hand, her main issue was the lack of food for women in later, this was considered a decision by anaesthetists which she tried to work around. Felt that she returned to work at a good time as many of the initial issues causing confusion had resolved.*

**17. Lucy works part time 12 hours (1 shift per week)**

Qualified as a midwife in Northern Ireland 18 years ago. Worked as a midwife in labour ward and wards in Hospital A, also worked in midwifery education for three years. Away from midwifery practice for eight years but during this time she trained as an antenatal teacher and provided birth preparation classes. Recently returned to labour ward following 10 years absence and underwent a Back to Midwifery programme to prepare herself for practice. The interview took place in her home.

**Reflections following interview:**

*This interview was left until last as I know this midwife well and I am familiar with her beliefs about childbirth. The interview was authentic and free flowing, Lucy spoke about her care of women in labour and how she endeavoured to make this an empowering experience. She quickly settled in to the unit six months after it opened and was accepted as a confident and experienced midwife.*

**Reflections following listening through all interviews:**

*Some midwives use more medicalised language than others. Busyness of unit was evident but not clear how this impacts on the care given in the individual rooms - women are not rushed but midwife may not get to her breaks or may not get much break between women. Moving out of the room quickly and may not be able to accompany women to the ward. Midwives seem to be providing individualised care which is often highly medicalised, inductions, epidurals - monitoring, the bath is not*

*used if the woman's membranes are ruptured. Michele talked about 'midwifery work vs. doctor's 'business' e.g. woman having food during their labour is an anaesthetic issue where the use of balls, showers, different positions in labour, is in the realm of midwifery. Language around the beauty of birth creeps in occasionally. Midwives are not pressurised to practice in certain ways except poor support due to busyness. Birth is highly managed, monitored, surveillance by midwife. Hospital B midwives talked more about what they wanted to hold onto from their old unit - music, water, and mobility.*

## Appendix 8 Interview schedule Phase I

These questions or a variation of them were asked of all six midwives, depending on the responses, various issues that emerged were discussed further.

Can you tell me about your experience of midwifery in this unit?

Can you tell me about the factors that impact on your practice?

Can you tell me about a time when you experienced a good day /bad day?

Has your midwifery practice changed over time/since you started working here?

If so, how did these changes come about for you?

What is the essence of midwifery practice for you?

What do you think it will be like for you when you are working as a midwife in the new unit?

## Appendix 9 Example of data coding

<b>1st iteration</b>	<b>2nd iteration</b>	<b>Emergent themes</b>
<p>Established ways – unchanging Types of midwives Responsive to demands of others Working for the team vs working for the woman Relationship with staff more important than relationships with women Managing the work Interchangeable midwifery staff Relationships with colleagues and institution Authoritative knowledge</p>	<p>Get through the work Midwifery skills not valued Acceptance and expectation of intervention as normal, status quo midwifery hierarchy valuing efficiency and task completion Organisational culture/conformity</p>	<p><b>Consensus of care/compliance with norms</b></p>
<p>Unwritten rules and sanctions Powerlessness Adaptation to environment, ‘fitting in’ Engineering agreement/acquiesce to institutional norms</p>	<p>Acceptance of medicalised environment oppression Intervention and technology as normal Avoidance of conflict</p>	<p><b>Powerless to change</b></p>
<p>Wonder of birth Sharing the joy Always special Variation in practice – variation in women’s needs Valuing midwifery skills, individualised care, relationships with clients</p>	<p>Letting birth be Best on night duty Less surveillance/potential for interference Having the confidence/foresight to avert/manage problems</p>	<p><b>New life and nice work</b></p>
<p>Discursive resistance, deviance Avoidance, subversion, Dissonance, frustration, anger Maintaining appearance of compliance Things change Others interfere – breaks, shared ownership of woman Fragmented care – dissatisfaction</p>	<p>Language of power Dissonance</p>	<p><b>Contested space</b></p>
<p>Valuing of medical and technological skills</p>	<p>hierarchy/status difference and</p>	<p><b>Changing practice and learning new skills</b></p>
<p>Better/worse More ‘medicalised’/privacy Too many consultants</p>		<p><b>Impending uncertainty</b></p>



## Appendix 10 Information for midwives Phase II

### **STUDY TO EXPLORE BIRTHING SUITE MIDWIVES' EXPERIENCE OF MIDWIFERY IN A HOSPITAL SETTING**

I am a midwifery lecturer in the School of Nursing and Midwifery, UCC and am registered as a PhD student with the Department of Midwifery Studies, University of Central Lancashire in Preston; this study is part of my PhD. In 2006 I interviewed midwives about their experience of working in a hospital labour ward.

#### **The study**

This part of the study aims to further explore the experiences of labour ward midwives and how they develop and use their skills in supporting women in labour. I am also interested in how the move to the new hospital may have impacted on midwifery practice.

#### **Procedure**

I wish to interview midwives about the care they provide to women in spontaneous labour; different scenarios may be used to explore aspects of care. I will also be interested in any birth stories midwives are willing to share with me, particularly those where midwives may have been instrumental in optimising the birth for the women.

If you are willing to be interviewed, I will arrange it for a time and place that suits you. It will probably take less than an hour. With your permission I will record the conversation to help me to recall our discussion. The recorder can be stopped at any time or the information deleted at your request.

#### **Anonymity and confidentiality**

All the information I receive will remain anonymous and confidential. Your identity and where you work will not be revealed. At the start of the interview you will be asked to provide a fictitious name which I will use in writing up the findings. The transcriptions will not contain any personal information which could identify you or the hospital.

There is no obligation on you to take part in the study. Even if you initially agree to participate you can withdraw at a later stage. In this situation, any information you have provided will be destroyed.

#### **Benefits of the study**

In exploring the experiences of midwives I hope to ascertain how midwives develop their skills. I will also be exploring how midwives contribute to normalising birth and providing women with a positive birth experience.

#### **Permission for the study**

Permission has been given from the Director of Midwifery and the Division of Obstetrics, Gynaecology and Neonatology. The study has received ethical approval from the Clinical Research Ethics Committee of the Cork Teaching Hospitals and the Faculty of Health Ethics Committee of the University of Central Lancashire.

**Rhona O'Connell**

XXXXXX

(Phone or Text any time)

## Appendix 11 Consent form Phase II

### Consent Form

**Study:**                    **Labour Ward Midwives' Construction of Childbirth**

Rhona O'Connell has invited me to be interviewed for this study and has informed me about the purpose of this study. I understand that this interview will be recorded and subsequently transcribed. I have been informed that the information I provide will remain anonymous and confidential.

I have been given the opportunity to select a fictitious name which will be used when the interviews are transcribed and in writing up the findings of this study. I have been informed that the transcriptions will not contain any personal information which could identify me, my colleagues or any woman in my care.

I confirm that I have read and understand the information sheet for the study and have had the opportunity to ask questions. These have been answered to my satisfaction.

I understand that my participation in this study is voluntary and that I am free to withdraw at any time, without giving any reason for my withdrawal.

Signed: \_\_\_\_\_

Witness/researcher: \_\_\_\_\_

Date: \_\_\_\_\_

## Appendix 12 Interview schedule Phase II

These questions or a variation of them were asked of the midwives, depending on individual responses, various issues that emerged were discussed further.

Can you tell me about your initial experience of working in this unit?

Can you tell me how it is for you now?

Has your experience of practice changed since you started working here?

Can you tell me about your experience of caring for women in labour?

Can you give me an example of being with a woman in labour where you considered that there was a good outcome?