

Keeping Birth Normal: Midwives' experiences in a secondary care setting

A Qualitative Study

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ATTESTATION OF AUTHORSHIP

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person nor material which to a substantial extent has been accepted for the qualification of any other degree or diploma of a university or other institution of higher learning, except where due acknowledgement is made in the acknowledgements

Signature:.....

Date:.....

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ABSTRACT

It has been said that within a secondary care setting, surrounded by medical influences, it is difficult for midwives to keep birth normal. This qualitative study has been conducted to answer the question: “What are midwives’ experiences of keeping birth normal within a secondary care setting?” van Manen’s (1990) hermeneutic thematic analysis was the method used to analyse the data generated from this study.

Eight “core” or hospital-based midwives were interviewed. The interviews were tape-recorded and transcribed into text and were analysed to come to a deeper understanding of the research question. There are three data chapters that reveal the themes that emerged from the data: “Being a midwife ‘is’ keeping birth normal”, “Stepping back and stepping in” and “Interacting with the doctor”.

The findings of the study revealed that seeing, knowing, and believing in normal birth leads to an embodied sense of “being” that infuses the way midwives practise. This knowledge needs to be passed on to junior midwives. Midwives judge when to use technology and intervention and the appropriate timing of intervention. The Relationships between medical practitioners and midwives is a key to keeping birth normal. Ultimately, it is through teamwork that normal birth is safeguarded.

The midwives in this study demonstrate a quiet yet determined courage to constantly question the decisions that might take away from the “normal” experience. They do not say that intervention is not necessary, but question the appropriate use of intervention. This questioning keeps normal birth a possibility.

CHAPTER ONE

Orientation to the study

Introduction

Keeping birth normal has been widely discussed in the literature for more than three decades, including suggestions regarding how this might be achieved (Balaskas, 1989; Banks, 2000; Inch, 1989; Page, 2000 & 2003; Warwick, 2001). Medical influences such as: epidural analgesia, continuous cardiotocograph (CTG) monitoring, artificial rupture of the membranes and induction of labour are suggested as some of the reasons why midwives find it difficult to “keep birth normal” within the secondary or tertiary setting (Donley, 1986; Papps and Olssen, 1997; Katz Rothman, 1991; Wagner, 1994; Warwick, 2001).

This qualitative interpretive study explores the experiences of eight “core” midwives that work in a secondary or tertiary delivery suite providing secondary care, concerning “keeping birth normal”. The purpose of this study is to gain a deeper understanding of midwives work within this setting and their encounters with respect to “keeping birth normal”.

In this chapter the research question, aims and method are profiled. Terminology or key words are included to ensure that those reading the study are aware of different maternity settings. Interpretations of phrases that may be different within the particular context of this study are also included, but acknowledging that some midwifery phrases are universal. Background information and justification of the study is also outlined.

To place this study within the current context a brief overview of midwifery in New Zealand as well as changes to midwifery practice and legislation are included. van Manen’s (1990) interpretive research approach calls for myself as the researcher to make explicit my personal and professional presuppositions and background related to this study. To conclude, an overview is presented of each chapter.

The research question and philosophical approach

The research question is:

What are midwives' experiences of keeping birth normal in a secondary care setting?

Looking into the midwives' experiences as they are lived fits with a qualitative interpretive approach, an approach that concerns itself with human science research and writing. van Manen's (1990) method of thematic analysis is a methodological way of engaging with the research and coming to a deeper understanding of human experience. van Manen's (1990) research method and Heidegger's (1927/1962) hermeneutic philosophy are part of the philosophical underpinnings in the study. The existentials or lifeworld themes of lived time, lived space, lived body and lived relationship to others guided the process of questioning, reflecting and writing in this study as outlined in chapter three. Midwives who work within a secondary care setting were interviewed to uncover meaning and gain insight into keeping birth normal within this particular setting. Their words created into text through transcribing have been reflected upon and interpreted to gain insight and understanding of the experience. Other literature including books, textbooks and journals have been referred to, to place this study within context of a wider understanding and differing views.

Aims of the study:

The aims of the study are:

- To identify the midwifery skills that are used to achieve normal birth outcomes.
- To uncover the midwifery knowledge and experience that enables normal birth to occur in this setting.
- To examine influences upon midwifery practice and normal birth.

Key words

There are many words that are characteristic to midwifery and childbirth. In order to ensure that the reader and writer have shared meaning some key words have been clarified further.

Lead Maternity Carer (LMC): The midwife, general practitioner (GP), obstetric specialist or hospital team who has been selected by the woman to co-ordinate and provide comprehensive maternity care, including the management of labour and birth.

Independent midwife: A midwife who is self-employed and has her own caseload of women she cares for throughout the childbirth process. The midwife might provide care for a home birth or a hospital-based birth.

Core midwife: A midwife employed by a District Health Board (DHB) to provide maternity care within a hospital facility or its surrounding community. In the delivery suite core midwives fulfill contractual agreements and therefore provide care for women who have an obstetrician LMC or GP LMC. Alternatively, core midwives provide care for women booked under the DHB as the LMC, known as closed unit or the hospital team. They also care for those women that present at the hospital that have had little or no antenatal care during their pregnancy. Core midwives also care for women of LMC midwives where the woman requires secondary care for medical or obstetric reasons.

Hospital facilities:

Hospitals are defined as Primary, Secondary or Tertiary facilities that mothers attend or are resident in for the primary purpose of receiving maternity care. (Ministry of Health, 2004, p.123).

Primary facility: there are 60 primary hospital facilities in New Zealand for women to birth with 'low risk' factors and designed for normal deliveries and healthy neonates. Also known as a Level 1 unit.

Secondary facility: there are 18 secondary hospital facilities in New Zealand, providing specialist obstetric and paediatric care including anaesthetic facilities but acting as limited obstetric and neonatal referral centres. Also known as a level 2 unit.

Tertiary facility: There are six large tertiary hospital facilities in New Zealand and two of them are within the Auckland Region. These are major referral centres for difficult

obstetric and neonatal cases and have intensive care facilities for women and babies. Also known as a level 3 unit. Tertiary facilities also provide secondary care for women.

Active management of labour

This term originated at the National Maternity Hospital Dublin. Its aim is to accelerate the birth process to no longer than 12 hours. This is through the management of labour by artificially rupturing the membranes and the use of a syntocinon infusion to increase the length and strength of contractions. The other aspect of their management is one-to-one care by a midwife or nurse. They note that there is a distinct differentiation between augmentation of labour when a woman has begun labour naturally and induction of labour, which interrupts the natural course of pregnancy and increases the need for pain relief. Their aim is to achieve low perinatal mortality rates, decreased caesarean section rates through labour dystocia and decreased operative delivery rates (forceps) (O'Driscoll, Meagher & Boylan, 1999).

Justification for the study

Within New Zealand there have been many changes since the Nurses' Amendment Act (Department of Health, 1990) restored midwives' right to practise autonomously. Midwives can choose to practise independently as self-employed midwives providing continuity of care, or as employed midwives working rostered shifts within a hospital setting. Over half of the midwives in New Zealand choose to work within a hospital setting as "core" midwives (Guilliland, 2002). Many of these midwives work within a secondary or tertiary setting.

Understandably there was a need to reclaim midwifery as an autonomous profession because of what had happened to midwifery historically (as outlined in chapter two). Midwives are once again separate from nursing, and are educated in a three year bachelor programme as direct entry midwives. A small number of nurses within New Zealand also elect to undertake midwifery education. A New Zealand Midwifery Council has been formed, separate from the New Zealand Nursing Council and, this too, identifies midwifery as a profession in its own right. As such, it is affected by the Health Practitioners Competence Assurance Act (HPCA) designed to protect the public where there is a risk of harm from the practice of a profession and to provide a

framework for the regulation of health practitioners (Ministry of Health, 2003). There is also a realisation that midwives are still needed within the hospital environment in the provision of secondary care services (Campbell, 2000). Midwives who work within hospital settings are being encouraged to join a separate union from the New Zealand Nursing Organisation (NZNO) known as Midwifery Employee Representation & Advisory Services (MERAS). This is to ensure that midwives are identified as completely separate from nursing and remunerated according to their increased autonomous role.

Campbell (2000) identified that the core midwife role is a challenge for the midwifery profession and the facilities in which they are employed. She questions how core midwives fit into the partnership model of care described by Guilliland and Pairman (1995) and supported by the New Zealand College of Midwives (2002). Guilliland and Pairman's (1995) midwifery partnership model was designed to challenge the dominant medical model because historically women's own knowledge and wishes were negated. Use of the word "partnership" has been debated because not all women want to make the decisions regarding their care throughout childbirth (Skinner, 1999). However, open negotiation and communication between women and midwives appears to be an important part of the partnership model of practice (Benn, 1999; Pairman, 1999).

Campbell (2000) indicated that the New Zealand midwifery profession has an expectation that midwives work "with women" whether they are self-employed or employed (p.1). Campbell (2000) identified that core midwives experience a challenge, as autonomous practitioners, employed by a facility. An autonomous practitioner is defined as someone who is self governing, not subject to external control (Cambridge Dictionaries Online, 2004). Kirkham (2000) claimed that midwives are unable to work in partnership with women in large obstetric hospitals because the constraints in these settings disempower midwives. Skinner (2003) stated that midwives are not only "constrained by their environment but also expected to provide care that is flexible and truly woman centred" (p.5). She suggested that one of the dilemmas a midwife might face is from women themselves. When a woman chooses to have an epidural anaesthetic that is available within the secondary care setting, but the midwife is committed to normal birth and helping the woman through labour without interventions,

it poses a challenge for the midwife. It is possible, however that women and midwives are influenced by the secondary or tertiary environment through the prevalence of technology on-site (Skinner, 2003).

There have been tensions between independent midwives and hospital core midwives during the transitional changes to midwifery since autonomy was restored to midwives, because of financial and staffing issues (Campbell, 2000). Campbell (2000) said that when she left independent practice and decided to become an employed midwife (as a result of family commitments) she felt, because of the comments directed at her, she was taking a backward step in her career. It was intimated that by working in a maternity facility her midwifery philosophy would be compromised. She states:

Moving from being self-employed to employed should not feel like you are taking a backward step professionally, that you now have to keep quiet about your midwifery philosophy or that you will now have to abdicate your professional responsibility of being an autonomous midwife (p.1).

The role of the “core” midwife or employed midwife working within a hospital setting is still an extremely important one. Within Section 88, of the New Zealand Public Health and Disability Act (Ministry of Health, 2002), midwives that are employed to provide secondary or tertiary care services seem almost invisible, as any references to secondary care is in relation to specialists or secondary maternity services (Earl et al., 2002). As Campbell (2000) identified, the legislation of section 88 is pertaining to the “funding schedule for the primary maternity care of women not for secondary care” (p.2). Midwives who work within secondary or tertiary care settings do care for women who are identified mainly as high risk. However, some women attending for District Health Board (DHB) care might be low risk women who are using the DHB as an LMC service.

In New Zealand 54,021 total live babies were born in 2002, 53,589 in hospital. Approximately 44% of all live births were in a tertiary facility and 40 % within a secondary facility. Therefore a total of 84% of babies are born in a secondary or tertiary setting (Ministry of Health, 2004, p.69). Although there is a philosophy of

women's choice, there still seems evident an accepted culture of birthing within a secondary or tertiary facility. Midwives are present at almost 100% of these births (Guilliland, 2002). Part of working in partnership with women is the provision of choice and the type of carer or LMC women would like throughout their pregnancy. Women can choose a midwife; a General Practitioner (although many are not practising obstetrics anymore), shared care between midwife and GP; a private obstetrician or closed unit/hospital care. 11.2% of women in 2002 booked with an obstetrician, 73.1% with a midwife and 9.6% with a GP (Ministry of Health, 2004, p.95).

However, there are women in New Zealand who never engage in any maternity care at all, or they have very little antenatal care. There are also women that require hospital care because of underlying complications - either obstetric or medical conditions - and are considered to have "risk factors". Some women require transfer from the primary care LMC to hospital secondary care because of a change in the level of care required that the primary LMC can no longer provide. Some conditions such as gestational diabetes mellitus, a concern within the Counties Manukau DHB, require specialist midwifery and medical care. Counties Manukau DHB was also shown to have the highest birth rate in New Zealand (Ministry of Health, 2004). In view of this high birth rate and a shortage of independent midwives a number of women use core midwifery services as their LMC.

Donley (1986) stated that, "Given support and patience, 85% of women can give birth normally and naturally. They don't need the routine intervention backed by high technology that is common practice in large obstetric hospitals today" (p.15). This is supported by the World Health Organisation (1996). Despite this assertion, the overall caesarean section rate in New Zealand was 20.1% in 2000, 22.1% in 2001 and 22.7% in 2002 (Ministry of Health, 2003a & 2004). Although caesarean section rates vary widely between different facilities and different countries, caesarean section rates have risen consistently over time (Warwick, 2001). An operative vaginal birth rate of 10.8% in 2000, 10.3% in 2001 and 9.6% in 2002 indicates a normal birth rate of 68.4 % in 2000, 67.6% in 2001, 67.7% in 2002 (Ministry of Health, 2003a & 2004).

Warwick (2001) suggested that a rising caesarean section rate is not solely the responsibility of obstetricians, but has many components. One of these components is the role of the midwife and the provision of midwifery care to women. She highlights the need for midwives to reflect on their practice and their “role in promoting normal birth” (p.154). In the larger obstetric hospitals, the number of interventions a woman receives in labour is not actually known (Banks, 2000), although there is growing evidence that the number is rising (Stewart, 2001). The midwifery philosophy is to keep birth “normal” for women (New Zealand College of Midwives, 1993). However, it has been suggested that midwives working in secondary and tertiary care settings are losing their fundamental midwifery skills, and hence their ability to achieve normal birth outcomes (Rowley, 1998). Skinner (2003) emphasised the need for midwives to consider the notion of “normal” very carefully. She said “the normal can be found and protected in the most complex of situations” (p.6). Even when a birth is no longer considered to be normal because of physical risk factors, midwives can help birth to retain a sense of social, cultural and spiritual importance.

The midwife as the birth attendant

Midwives have worked independently in New Zealand for over 13 years now and many women seem happy with the current maternity service. Approximately 73% of women have a midwife as their LMC (Ministry of Health, 2004). Earl et al., (2002) questioned “If our model of midwifery in New Zealand is so good why are the caesarean section and intervention rates still going up?” (p.32). It therefore seemed important to explore the midwives’ role in keeping birth normal.

Within this study it has been my aim to talk with midwives about maintaining normal birth outcomes within secondary and tertiary care settings, some of which have high intervention rates. Numerous factors affect the outcome of childbirth and one of the factors is the influence of the birth attendant (Douche, 2001). Many midwives who work in a secondary or tertiary setting have a wealth of knowledge and experience that can influence birth outcomes. Rowley (1998) stated that it is important midwives “learn from each other” (p.35). The midwives that work within the secondary and tertiary environment have skills that help women towards a normal birth, and the intention of this study is to bring to light these skills and their stories of working within this “high

technology” environment. Wide variations in birth outcomes exist between hospitals (Bulger, Howden-Chapman & Stone, 1998; Johnson & Ansell, 1995; Ministry of Health, 2004). The maternity environment is so pervasive that it affects how midwives practise in that particular setting (Hunter, 2000). Skinner (2003) believed that the new challenges to be faced now relates to “managing care in an environment which, to a large extent, remains dominated by a techno-rational model of birth”(p.4). This study aims to encourage midwives in secondary and tertiary settings to share their practice that assists women to achieve normal birth outcomes.

Midwifery perspectives re normal birth

Campbell (2000) asserted that midwifery research is just as valuable as medical research. She identified that there is a need to support core midwives to undertake research, which will result in recognition for the midwives in their profession. She highlights the benefit that the research will have for women who give birth in New Zealand. Murray (1996) stated, “Midwives have the potential of a unique and privileged relationship with women during important life events. This brings wider social responsibilities and functions, to document, to research, to debate, to defend and to advocate” (p.vii). Conducting this study will contribute to building a body of knowledge related to core midwifery. Evidence based practice is an important part of informed decision making within midwifery practice and for consumers (Murphy, 1997).

With many changes to midwifery practice since 1990, New Zealand midwives have found themselves reflecting on the midwifery practice they provide within the particular settings in which they work. Such reflections on practice have been presented at conferences such as the New Zealand College of Midwives (NZCOM) 7th Biennial Conference (2002) and the Joan Donley Midwifery Research Collaboration Forum (2003). Internationally, reduction of medical intervention and promotion of normal birth has been discussed at the 26th Triennial Congress of the International Confederation of Midwives Convention in Vienna (2002), and at the National Symposium on the current evidence base for normal birth in Preston, United Kingdom, in October 2001 and again in October 2002.

The “Keeping Birth Normal” Midwifery Research Conference in Wellington, New Zealand in November 2003 aimed to address issues related to this important topic. The Centre for Midwifery and Women’s Health Research at Auckland University of Technology (AUT) outlined a study at the conference entitled “Student perspectives: How do midwives keep birth normal?” However this study has yet to be published. Websites listing current thesis topics within New Zealand are also being set up to help midwives identify different studies being conducted. This will be of great benefit to all midwives currently undertaking research, and also for those midwives wishing to conduct research in the future.

I was unable to locate any research that specifically looked at core midwives’ experiences of keeping birth normal in a secondary and tertiary care setting within a current New Zealand context. Hunter (2000) completed a qualitative study on the paradoxes of providing intrapartum midwifery care in small maternity units as compared with large obstetric hospitals from a LMC independent midwifery perspective. She found that LMC midwives practised differently within different contexts. The LMC midwives in small maternity settings were more autonomous and had more clinical freedom without the influence of technology. However, with this freedom came an awareness of increased responsibility, without medical assistance being always on hand as within a larger obstetric hospital.

Crabtree (2002) completed a qualitative study using feminist analysis. She explored how normal birth was constructed from an LMC independent midwifery perspective. She found that LMC midwifery practice and women’s birth experiences “occur in a contested context that remains firmly entrenched in a medically dominant model of care,” and that “the medical model is the default mode: it is always there and is taken as the ‘right’ way to ‘do’ birth unless it is actively contended” (p.iv). The findings in Crabtree’s (2002) study may also relate to this study. This study will describe how core midwives adapt to keeping birth normal within the environment of the secondary care setting, which is considered to be medically dominated (Kirkham, 2000). Further literature related to “normal birth” has been outlined in the literature review.

Study context

All participants are from the Auckland region. Within Auckland there are two tertiary maternity facilities, two secondary care maternity facilities and four primary care maternity facilities. Three of the primary maternity care facilities are part of a District Health Board (DHB) with a tertiary maternity facility (Middlemore Hospital, South Auckland) and the other primary unit is a private/public stand-alone maternity facility. The number of babies born within the greater Auckland region in 2002 was 19,970, 17,128 of whom were born in a secondary or tertiary facility (Ministry of Health, 2004, p.67-68). Demographically the median income in Auckland City is \$22,300 and in Manukau it is \$19,000 (Statistics New Zealand, 2001). The greater Auckland region is also known for its multicultural population and there are people from many different ethnic origins. Statistics New Zealand (2001) describes the ethnic population as:

Auckland City: European 45.2%; Maori 9.3%; Pacific peoples 22.3%; Asian 20.0%
Manukau City: European 31.6%; Maori 21.6%; Pacific peoples 31.7%; Asian 11.1%

Auckland City has 9.8% of the population of New Zealand and is the largest in size, and Manukau City has the second largest at 7.6% (p.1-2). However, the Maori and Pacific population in Manukau City is virtually double that of Auckland City. Much of my own experience has been working in Manukau, but the study participants were drawn from both cities.

Context of midwifery practice

Many core midwives have chosen to stay within the hospital setting because they have seen their independent colleagues on call constantly for 24 hours a day, 7 days per week. Midwives have families and full lives. Some find that the practice of being on call all the time is not suitable to fit in with their lifestyle. There are options for practising core midwifery in many clinical areas for example: community midwifery, postnatal ward, antenatal ward, maternal and fetal assessment, diabetes, high-risk clinics, midwifery educator, or delivery suite. Some midwives choose to work as a hospital or “core” midwife only, and some independent only. There is a range of midwives with varying experience within delivery suites, from new graduates to midwives with over thirty years of experience.

The core midwives that were part of this study had between two and thirty or more years of experience. These midwives, who work in delivery suite providing secondary and tertiary care, have a wealth of knowledge accumulated over many years of clinical practice, that they share with many of their colleagues. An attempt to harness some of the knowledge that has been shared with me became my goal, as I feel that the wisdom and experience of a very dedicated group of core delivery suite midwives needs to be recognised.

My background

My beginning perception of birth was from a very young age when I used to hear my parents regale the story of my birth. My two older brothers were born at home, as was the expectation in England at that time. My mother and father emigrated to New Zealand prior to my birth in 1968 and, at that time in New Zealand, the expectation was that women gave birth in hospital. My mother had a precipitate labour with me and I was born at home on the bedroom floor. My father says he played midwife along with my godmother and my placenta was buried in the back garden. A general practitioner attended my mother at home, but both my father and mother felt that he was less than satisfactory in his provision of care. After giving birth, my mother was taken into the local primary care facility of that time for the mandatory ten days of bed rest. My mother recalls a midwife who petrified her and “prepped” her after I was born, because she didn’t get it before – so she was given a pubic shave, an enema, and shower. She recalls my older brother who was 20 months old at the time standing outside the window crying because he wasn’t allowed in. With this image in mind, she told me when I was training to be a midwife, “I hope you remember not to be like that”. However, I did grow up with a sense of what it was to birth normally at home.

I trained as a midwife in the United Kingdom within a big tertiary unit. I then had a large amount of experience with a community midwife whom delivered a small caseload of women at home and looked after women antenatally and postnatally. I also had some time with a midwife acupuncturist. Mostly the women gave birth within the delivery unit and were cared for by hospital midwives, but they had the same community midwife for the rest of their care.

When I returned home to New Zealand in 1997 I discovered that midwifery was different in New Zealand. The advent of independent midwifery and the recognition by the government of autonomous midwifery practitioners was new to me. I began working at a tertiary hospital in Auckland and was confronted with the complexities of practising within a unit that has many different LMCs. I found the relationships between independent midwives, midwives from primary care units, obstetricians and GPs quite complicated. I also found that the care that I was expected to provide was complex, especially trying to practise within the realms of my own standards.

I have been a midwife for over ten years, working within “high risk” antenatal, postnatal, transitional care, and delivery suite settings. I have also delivered babies in an intensive care unit. Why do I work in these high-risk settings? I think it stems from the fact that I feel it is just as important for women within these facilities, many of whom have great socio-economic needs, and therefore limited choice, to receive good quality midwifery care.

When I started searching for my thesis topic one of the midwifery students expressed how much she learnt by listening to the experience of the midwives working in delivery suite. The students and junior midwives gained immensely from the “tea room” conversations, where so much midwifery knowledge is informally shared. I started thinking about my midwifery colleagues and the knowledge and skills they have shared with me. Importantly, these midwives shared the skills that they have developed to achieve normal birth outcomes within their secondary or tertiary facility. As senior midwives working within the unit they also support independent practitioners in the provision of care beyond their scope of practice. In the facility where I work it is considered to be midwifery led. There is also an expectation by the doctors and midwives not to intervene unless necessary, although some still do. I feel encouraged to develop skills and experience to keep birth normal, even in the light of complications. My underlying philosophy is that women are designed to give birth vaginally. However, I recognise the need for life saving caesarean sections from time to time.

Addressing my presuppositions

To address my presuppositions, prior to commencing data collection one of my supervisors interviewed me. The content of the interview assisted me to reveal what my presuppositions were. I then kept these in mind during the process of this study. It seemed apparent that the context of where I work has an influence upon on my midwifery practice. Midwifery-led care is a large part of the philosophy in the unit where I work. I also recognised there are particular skills of observation and practice, as well as experiential knowledge, knowing and intuition when you are with women in labour. I believe that there needs to be encouragement for midwives to make autonomous decisions regarding care of women in labour and reducing medical intervention within the secondary care context.

I think that the overall preference should be for a vaginal birth, although I recognise that caesarean sections and instrumental deliveries have their place in an emergency. My preference then would be for a ventouse rather than a forceps delivery. In my experience some women can perceive they have had a normal birth even though they may have had a ventouse as the baby is still born vaginally. From my perspective a ventouse is not a normal birth because it is a medical intervention.

The relationship with women in labour is central to the provision of midwifery care. However, it is not always easy to interpret what a woman truly wants in labour, and not every woman is determined to keep birth normal. Some women request interventions, by using statements like “When the doctor breaks my waters the baby comes,” or by asking for an epidural.

Varying definitions of what people have determined as “normal” was a theme I thought about. Perhaps this was because I had been thinking about how I was going to start the interviews and wanted to know what the participants thought “normal birth” was in the first place. However, the differences in interpretation were unexpected and this will be discussed in the data chapters.

The doctor-midwife relationship was a theme that I thought would emerge, because of my experiences working with doctors within secondary and tertiary settings. However, I

was not aware of the different ways they can affect each other in relation to normal birth. I will discuss this in chapter six.

I also thought that working with women through labour in normal birth would be a part of keeping birth normal, as well as active management of labour and the primigravida protocol. These guidelines for progress in labour also include the use of artificial rupture of the membranes and syntocinon augmentation, which is part of the medical active management of labour within the secondary and tertiary environments (O'Driscoll, Meagher and Boylan, 1999).

Overview of the structure of the thesis to come

The New Zealand College of Midwives (2002) standards for practice acknowledges both the importance of women being at the centre of her care, and the midwife working with the woman to achieve a normal birth. The standards emphasize that this should ideally be achieved in a continuity of care model. However, within the secondary or tertiary care setting women are cared for by core midwives who are unlikely to “know” the woman. The midwives in this study reveal how they still desire the woman to be at the centre of her care, and how they work with women to keep birth “normal” in spite of complications, policies, protocols, guidelines, or the need for medical input.

Chapter Two: Literature review

A review of the literature related to this study is explored to help define “normal” and I outline the notion of “normal birth”. Historical and social literature describing influences upon normal birth and midwifery are examined. Place of birth and pain relief are discussed, including their influence on normal birth and midwifery. The literature surrounding the medical and midwifery models of care, technology and intervention, and the influence of “risk” management are examined in association with normal birth. Historical influences upon Maori, and literature surrounding cultural experiences are outlined. The literature in relation to midwives’ experiences is discussed. This includes the midwife-mother relationship, midwifery practice and “keeping birth normal” within the current context.

Chapter Three: Methodology and Method

This chapter outlines van Manen's (1990) hermeneutic interpretive research method, which includes the philosophical underpinnings related to this study. The design and methods are outlined with particular regard to ethics, recruitment of participants and gathering the data. The process of analysing the data, attention to the trustworthiness or rigour of this qualitative study, presentation of themes and the key to data interpretation are defined.

Chapter Four: Being a midwife "is" keeping birth normal

This chapter, as well as the following two chapters, presents analysis of the data that has been obtained from interviewing the eight core midwife participants in this study. In this chapter, the theme "Being a midwife 'is' keeping birth normal" emerged from the data and has been outlined with further analysis. Within the sub-themes the midwives reveal their notion of normal birth: seeing "is" knowing normal birth, a belief in normal birth and developing a "little rule of thumb".

Chapter Five: Stepping back or stepping in

Stepping back or stepping in, is the main theme of this second data chapter and relates to the decisions about whether to intervene or not. The decision to step in or step back might be influenced by the need to share and pass on midwifery knowledge or to influence normal birth outcomes with students and more junior midwives. The decision to step in or step back might also be related to the need for some minor interventions to prevent what are considered to be major interventions. Midwives are influenced by women as to whether they step in or step back, because women themselves actively influence normal birth by refusing or requesting interventions.

Chapter Six: Interacting with the doctors

In this third data chapter the participants reveal that they work within a medically influenced environment. They discuss and identify actions they may take and how they interact with the doctors to keep birth normal. They also reveal the deterrents to keeping birth normal.

Chapter Seven: Discussion and conclusion

This final chapter addresses the research question and aims of the study. It brings together and discusses the meanings from the three data chapters. From the findings of this study the implications for practice, education and future research will also be discussed.

Summary

In this chapter the research question and aims have been introduced. There is also an overview of the research method that includes an explanation of key words appropriate to the study and justification for the study. This study explores midwives' experiences of keeping birth normal within a secondary care setting. A large percentage of women give birth within a secondary or tertiary care setting and midwives generally attend all the births. Birth attendants have been identified as having an influence upon birth outcomes, and over half of the midwives in New Zealand work within a hospital facility - thereby justifying the need for this study. This chapter also places the study within a context of midwifery research and practice. My own background and presuppositions have been outlined and I conclude with an overview of the structure of this thesis.

CHAPTER TWO

A Review of the Literature

Introduction

As stated in chapter one, the research question is: “What are midwives’ experiences of keeping birth normal in a secondary care setting?” In New Zealand a large percentage of women give birth to their babies within a secondary or tertiary care setting (Ministry of Health, 2004). Core midwives care for many of these women. The literature relating to the research question was explored to understand more fully the historical, cultural and social influences that have affected midwives’ experiences of “normal birth”.

In this chapter the literature related to this study is reviewed in order to place it within a context of past and current research (Polit & Hungler, 1997). van Manen (1990) stated that researchers need to take into account “the socio-cultural and historical traditions that have given meaning to our ways of being in the world” (p.12). Therefore it is important to explore the literature that gives further meaning to the research question and frames it within a body of knowledge.

van Manen (1990) advises that in the hermeneutic process of inquiry a review of the literature is undertaken after the narratives from the participants are analysed. This process was followed to ensure the interpretation came from the data of the participants, and not from what other authors have written in relation to the research question. Upon completion of data analysis, references were searched electronically and manually from current literature to fifty years ago, in order to obtain historical literature. Literature was obtained by accessing Auckland University of Technology library, Middlemore Hospital library, resources from midwifery colleagues, and through electronic searching. Databases were accessed through OVID, Ebsco, CINHAL, Medline, Psycinfo, and Blackwell Science.

In this chapter I will explore the literature related to “normal” and the notion of “normal birth”. The historical influences upon midwives and normal birth will then be discussed.

The effect of place of birth upon normal birth will be considered, including the effect of pain relief options in larger obstetric hospitals. The models of care that are present within the secondary and tertiary hospital settings will be explored. This includes the literature relating to technology, intervention and the advent of “risk” management of childbirth. The literature related to midwives’ experiences will be examined, and will include the midwife-mother relationship and midwifery practice within the current context.

Defining “Normal”

In order to discuss what has been established as “normal” in relation to birth it seems important to first consider what is defined as “normal”. “Normal” is generally considered to be that which is: typical; usual; standard; a regular pattern; occurring naturally (Merriam-Webster Online Dictionary, 2004). Stedman’s Medical Dictionary, (2004) also describes “normal” as being not diseased or having been subjected to an experimental procedure. It is also defined as performing the proper function; not abnormal; regular; natural; according to the established norm (Brainy Dictionary, 2004). It appears from these definitions that “normal” can have different meanings depending on the context. How then is “normal” defined in the context of the literature of childbirth?

The notion of “Normal” birth

Birth with minimal intervention or without technical or medical intervention is considered to be normal (Duff, 2002; Page, 2000). In New Zealand the Ministry of Health (2003) defined normal birth as “the birth of a baby without obstetric operative intervention (vaginal birth)” (p.146). Although a woman may have a vaginal birth without obstetric operative intervention such as a forceps, ventouse or caesarean section, she might have received many other interventions throughout the process of labour. For example: she may have an induction of labour, epidural analgesia, artificial rupture of the membranes, syntocinon augmentation or episiotomy (Downe, 2001). Perhaps it is easier to describe normal by “what it is not” rather than by “what it is”. The World Health Organisation (1996) 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 mother and infant are in good condition (p.3).

This definition of what normal birth is does not attempt to define normal birth by “what it is not”. However, the World Health Organisation (1996) does indicate that the risk status of the pregnancy and the course of labour and delivery need to be taken into consideration. The New Zealand College of Midwives (2002) states that “Pregnancy and childbirth are part of the ‘normal’ life experience of women. The majority of women have the ability to conceive, give birth and breastfeed without problems” (p.36). It goes on to say:

Midwifery practice defines ‘normal’ on a one-to-one basis with women. The process is based on informed choice and informed consent. Recognising the individuality of each woman’s pregnancy and childbirth experience. Midwifery practice recognises points of referral during this process when the health of the mother and/or baby are in question (p.36).

Informed choice and informed consent are related to the sharing of information and a mutual understanding of the implications of the choices made. This involves the discussion of birth options and involvement in the decisions related to women’s pregnancy, labour and birth, as well as consenting to any interventions or procedures throughout the process. Women are placed at the centre of their care, working in partnership with the midwife or LMC (New Zealand College of Midwives, 2002). Working in partnership with women respects the knowledge women have and their intuition about their own bodies (Smulders, 2002). Fawdry (1994) asserted that the complexity of each woman does not make it easy to divide her into a normal or abnormal category as supported by the above New Zealand College of Midwives (2002) definition of “normal”.

At a Normal Birth Conference in Wellington, New Zealand (2003) it became clear that midwives and consumers had different perspectives on what normal birth meant to

them. For example some midwives felt that home birth without any interventions is normal, whereas other midwives had the view that if a woman wants an epidural as part of her birth experience then that is normal for her. Downe (1998) suggested that midwives have long seen themselves as the experts of “normal birth” with the assumption that normality needs no explanation. However as Downe (1998) stated, “Normality is not a fixed concept, it is socially defined and changes over time” (p.86). Therefore people define normality depending on what is currently acceptable. For example, Dixon (2003) described the perception among many women that the baby cannot be born unless the waters are broken. This view might contribute toward the widespread frequent use of amniotomy or artificial rupture of the membranes (ARM) in labour.

Like Downe (1998), Kitzinger (2000) also recognised the social and cultural influences upon birth. Kitzinger (2000) stated “The culture of society is made up of all the meanings that are so deeply inscribed into our everyday actions that we rarely question them. It is most evident in the great transitions of life: birth, puberty, marriage and death” (p.11). She suggested that we live in a developed society that medicalises childbirth, where childbirth usually takes place in a hospital and is determined by risk. Page (2000) supports the view that “normal birth” is defined by the culture, in which we live and practice. She perceived that normal birth is extremely difficult to protect within the current climate of medical intervention such as epidurals and induction of labour.

It would appear that normal birth is defined and viewed from a number of different perspectives (Ministry of Health, 2003; New Zealand College of Midwives, 2002; Normal Birth Conference, Wellington, 2003; World Health Organisation, 1996). Some writers even question the very notion of normality as existing outside of society and culture. This discussion which brings into question the meaning of “normal birth” and “normal”, led to exploration of the historical forces which have shaped, and still do shape, that which is perceived as “normal” today.

The midwife and normal birth

Historically, midwifery is one of the oldest professions in the world. However, midwives have struggled throughout history to maintain their role in caring for women

in childbirth (Arney, 1982; Beech, 1998). It is impossible to cover all the historical literature within the constraints of this thesis. However, for many centuries British midwives could not get an education and did not attend university; therefore most midwives learnt their midwifery through experience (Arney, 1982). Teaching was gained from midwife to midwife. Midwives believed in the concept of normal and natural childbirth and “being with” or attending women. The process, except for maybe some herbal remedies, was not hurried and was interfered with very little. Perhaps it could be argued that the midwives had no choice but to simply observe the process of birth that took place, for they were helpless to do otherwise.

In sixteenth century Britain, midwives were associated with the realms of normal childbirth and barber-surgeons were associated with the abnormal (Arney, 1982). Midwives were to call a surgeon if anything went wrong with labour so that they could “extract a child that was not expelled normally within a reasonable amount of time” (Arney, 1982, p.23). The techniques were usually fatal for the child and for the mother as well. However, it was the midwife who decided when birth was abnormal, because she was the person that would refer the woman to the barber-surgeons. The blurring of these normal and abnormal boundaries occurred through the development of the scientific approach to childbirth and the introduction of the obstetrical forceps in the seventeenth century. This crucial point in history led to the male dominance of childbirth. Ultimately a lack of education for women-midwives meant they did not have a recognised body of knowledge on which to build their profession (Arney, 1982).

Factors that developed through history resulting in midwives’ struggle for survival were financial restraints, patriarchal dominance, and medicalisation of childbirth. The subsequent hospitalisation of childbirth, and the control of the midwife through legislation, meant that midwives became almost extinct (Arney, 1982; Donley, 1998; Mein Smith, 1986; Papps & Olsen, 1997; Tew, 1978). These social and historical processes meant birth was no longer the domain of the midwife, and birth was no longer primarily seen as a normal process (Papps & Olssen, 1997). Wagner (1994) claimed that defining women and babies into “normal” and “abnormal” was the start of the struggle for control of birth by the medical profession. Dividing women and babies into low and high risk helped to perpetuate this further.

One of the main social issues from the 1920's onwards that influenced the hospitalisation and medicalisation of childbirth was maternal mortality from puerperal sepsis (Donley, 1998; Mein Smith, 1986; Papps & Olsen, 1997). Mein Smith (1986) indicated that the threat of sepsis lead doctors to want to make childbirth "as safe as a surgical operation"(p.29). Subsequently, issues related to the management, location and provision of care to women during childbirth have been examined (Papps & Olsen, 1997).

By the 1930's and 40's the majority of women gave birth in hospital. Many hospital based midwives worked under the supervision of a doctor and many women trained as maternity nurses but were restricted by legislation and hospital practices. However, according to the legislation of that time, domiciliary midwives still worked independently in the community free from the supervision of obstetricians. Some GP's supported midwives as medical backup in the community by attending home births if required (Donley, 1986).

Corkill's (1948) textbook for nurses and midwives outlines acceptable hospital practice for the time, which included preparing the woman to give birth as if it were indeed a sterile or surgical procedure, "The bowel should be emptied" and "The pubic hair should be shaved"(p.92). Preparation for delivery included, gown, cap and mask for the doctor, douche and swabbing with a soapy solution and draping with multiple sterile guards. Women were moved to the confinement room to give birth. There were strict instructions as to when the nurse should send for the doctor. The doctor was to be notified at once when a labouring woman came during daylight hours so as he could rearrange his schedule if necessary. However, at night if everything was normal it was not necessary to notify him until morning, unless he was summoned to the delivery. The contrast between daylight and night time meant that midwives working at night had increased autonomy and birth could be normal. This textbook demonstrates the organisation of hospital routines to the suitability of the medical profession, with a change in autonomy for midwives between night and day.

In the 1950's midwifery became a part of nursing training, and all midwives had to be nurses prior to undertaking midwifery training. The Nurses and Midwives Acts of 1925 and 1945 became the Nurses Act in 1971 (Papps & Olssen, 1997). Midwives were dropped from the title and midwives were reduced to nurse status. This destroyed midwives' independent practitioner status, because they were required to work under the supervision of a doctor (Papps & Olssen, 1997). There was a division between hospital based midwives (considered to be doctors' assistants), and domiciliary midwives who, because they did not work in the hospital environment, were considered to be lowering the standards of maternity care (Donley, 1986). The antagonism between hospital based and domiciliary midwives was altered when they became united in a quest in the 1980's drive to save their profession.

It was however consumers that came together to form "Save the Midwives" society (Donley, 1986, p. 108). Women and midwives collaborated politically to bring about change, and through the 1990 Amendment to the 1977 Nurses Act regained their autonomy to practice independently from the medical profession (Guilliland & Pairman, 1995). Helen Clark was the Minister of Health at that time. Her statement in the Department of Health (1990) Nurses Amendment Act included:

Statistics reflect the benefit of a commitment to natural childbirth, of continuity of care of the client and the rejection of unnecessary intervention. The majority of women have been socialised to perceive birth as an illness. The challenge of this legislation is to change that (p.2).

Midwives and women had reclaimed their trust in the normal process of birth. They asserted that women - not medicine and nursing - should have control over their childbirth experiences (Swain, 1981). Women wanted a different kind of birth experience within the hospital setting, linked to the need to bend the inflexibility of hospital routines (Dobbie, 1981). The debate in the late 1980's and 1990's about who had the control over birth and place of birth were intertwined (Guilliland & Pairman, 1995; Hedley, 1987).

Place of birth

Most women back in the 1920's in New Zealand had their babies at home or in a small home run by a maternity nurse or midwife. At this time 65% of births took place outside of hospitals. GP's ran private maternity "hospitals"; many were converted houses outnumbering public institutions five to one. These were directly linked to their financial remuneration. With the threat of sepsis regulations caused many private hospitals to close down. Domiciliary midwifery or home births were still available because women were worried about sepsis in hospitals. However, as more public hospitals were built, the services provided by domiciliary midwives declined (Mein Smith, 1986). Domiciliary midwives worked alone and sought doctor support only if there were difficulties.

When Paget, a rural GP with 30 years' experience, advocated the building of small maternity hospitals because of the scattered nature of the New Zealand population. Conversely, Dr Jellett, an obstetrician who trained at the Rotunda hospital in Dublin and emigrated to New Zealand in 1920, visualised the building of large maternity hospitals. Although this was to provide more economical and efficient services rather than running smaller units, it also sought to improve the training of midwives and medical students (Mein Smith, 1986).

Fifteen years later in 1935, 78% of children were born in hospital (Mein Smith, 1986). There were many political and social influences that brought about this change. By 1935 the medical profession controlled obstetrics, and with a medical practitioner in attendance, most women had their baby in hospital (Mein Smith, 1986). Banks (2000) observed that the change in home birth to hospital birth occurred twenty years earlier in New Zealand than it did in Great Britain and ten years earlier than the United States of America. It was suggested that the move to hospital birth was influenced by concern for maternal mortality, indicating that more women died during childbirth in New Zealand than any other developed nation, other than the United states, at that time. However, Mein Smith (1986) argues that the true reason was because medical professionals defined maternity services. Obstetric care was financed by central government in approximately 1939, and all women did - and still do - have free access to maternity care.

Large obstetric hospitals supported the rise of Obstetrics and Gynaecology as a separate medical specialty (Donley, 1986; Wagner, 1994). Bonham (1982) reported that almost 99% of births were in hospital and 60% were supervised by GPs. The obstetric profession as specialists within the field of childbirth overtook GPs. Home births were only conducted if a GP was prepared to back up the domiciliary midwives (Donley, 1986).

According to Bonham (1982) the advantages of GP care was “a good family doctor-patient relationship with associated emotional satisfaction”. The Disadvantage was a lack of experience in managing abnormality in primary care facilities that “merely provide aggregated domiciliary confinement” (p.1). He obviously supported childbirth within large obstetric hospitals regulated by obstetricians. Besides the recommendation for regionalised services, Bonham (1982) also recommended that obstetric referral guidelines be put in place. Those women requiring obstetric referral and considered to be high risk included all primigravidae (first pregnancy), all women over 30, women with medical or obstetric complications, stillbirth, neonatal death, and any complication of a current pregnancy. Donley (1986) disagreed on the basis that inclusion of all primigravidae women, and women over 30 abnormalised childbirth for women.

The regulation of GPs and the rise of the obstetric specialist in larger hospitals was to the detriment of small units and services provided by GPs and midwives within New Zealand communities. Through regionalisation of services and the centralisation of more “sophisticated units”, obstetricians encouraged the closure of smaller units. This also meant that GPs “would be deprived of facilities in which to practice obstetrics” (Donley, 1986, p.63). With the advent of regionalisation, fears about quality of care within smaller maternity units were being called into question. A study by Rosenblatt, Reinken and Shoemark (1985) evaluated the safety of small hospitals described as level one units. Most of these were rural and staffed by midwives and GPs. They found that the perinatal mortality rates within level one, or primary care units were significantly lower than level two or three units, known as secondary and tertiary care facilities. Therefore women of low risk might fare better in these smaller units than the level two or three units. This report was ignored by the New Zealand government as it did not

support the centralisation of services into larger obstetric hospitals (Donley, 1986). Wagner (1994) also found that the scientific evidence did not support the move to birth within larger obstetric hospitals. He suggested that larger hospitals served obstetrics by reducing the competition from midwives, and patients were readily available as teaching objects for students learning the clinical expertise of obstetrics. Thus Larger hospitals helped redefine pregnancy and childbirth as a medical problem rather than a natural event.

Internationally, throughout history, “place of birth” is an issue for many women and is closely linked to the development of the midwifery and medical models of care (Katz Rothman, 1991; Mander, 2002). Controlling the place of birth and moving women from their homes into hospital was one way obstetrics gained control over childbirth to the detriment of the midwife (Arney, 1982; Banks, 2000). In Great Britain, Tew (1978) reviewed the political, legislative and statistical influences that encouraged the majority of women to move from home to hospital. She found that hospital was not the best place for women without complications to give birth. However, by the time of her review, the belief that hospital was the safest place to give birth was firmly entrenched within society.

Currently the majority of women (and midwives) appear to firmly believe that hospital is the safest place to give birth (Donley, 1986; Parratt & Fahy, 2004). Katz Rothman (1991) believed that the place in which a woman gives birth is not what matters. Rather, she suggested that it is “the attitudes of the attendants – the beliefs, values and ideas they hold about women, babies and birth” (p.48). Identifiable risk factors also influence the decision about where a woman should give birth. However, determining whether a woman may require medical assistance or not is difficult to predict (Enkin et al., 2000, World Health Organisation, 1996).

The place of birth directly affected how “normal birth” was perceived (Papps & Olssen, 1997). Because of the hospitalisation of birth, the control of birth came into the hands of the obstetrician and affected midwives, GPs and women. One of the factors that influenced women to deliver in hospital rather than home was the promise of pain relief.

The promise of pain relief

Although there were problems with sepsis in hospitals, part of the attraction to birth in hospitals for women from the 1930's was the promise of pain relief and a painless childbirth. However, this often led to intervention in the form of forceps because women were sedated and unable to push, hence the development of the management of childbirth and medical control (Mein Smith, 1986). Papps and Olssen (1997) also believed the issue of pain relief was linked to increased medicalisation of childbirth. Mein Smith (1986) outlined that labour was thought to be "abnormal and pathological" and that a normal case was "fraught with pain and penalty" (p.82). The pathology was thought to be linked to the pain and therefore drugs were used for "twilight sleep" so those women were unable to recall the events of labour. It was recognised that this could affect the infant, sometimes resulting in death or breathing difficulties. The need to administer drugs was the primary reason a doctor's presence was required (Mein Smith, 1986). Once women were in hospital they were captive to increased monitoring and surveillance during labour (Mein Smith, 1986; Papps & Olssen, 1997).

A contrasting alternative to medicalisation and the need for pain relief in childbirth was the work by Grantly Dick Read (1954), a doctor who first released a book titled "*Childbirth without Fear*" in 1942, which advocated for natural childbirth. Read recognised the significance of emotional factors affecting women in childbirth. He argued that if they had faith and believed in a normal and natural outcome of childbirth then they coped better and appeared to experience less pain and anxiety than those that did not. He highlighted the importance of the birth experience for women and coping with pain.

Within the current context, the historical influence of the need for pain relief by women has effected midwives' experiences, which is linked to caring for women in labour. Leap (2000) interviewed 10 midwives in a qualitative study that found a difference in the concepts of women's need for pain relief in labour and midwives working with women and their pain. The former is more from a medicalised view, and the later a midwifery view. Leap, however, found that some midwives do work with women and their pain in hospital settings, while other midwives can take a "pain relief" approach out of hospital into home birth settings. She identified pressure within the hospital

setting to offer pain relief, because of practitioner discomfort, and reactions to the noise women make. Hunter (2000) also found in her study the intolerance of noise within the larger obstetric hospitals. This was linked to the benefits of technology and the perception that women do not have to suffer because of the availability of epidural anaesthesia. Beech (1998) acknowledged that the use of medical intervention, such as artificial rupture of membranes and syntocinon augmentation, has meant that few women were able to cope with the pain.

Leap (2000) also discussed the perception that pain is a normal part of normal labour, and midwives need to help women work through their pain in labour. However, if the labour is deemed to be abnormal, she advocates that pain relief should be offered. Leap also recognised that it is difficult to predict how women will cope with pain in labour. Historical influences meant that the need for pain relief became part of what was considered to be “normal”. Leap perceived that the differences in the need for pain relief as opposed to working with women and their pain in labour is key to the notion of keeping birth normal. These different approaches to pain in labour stem from the medical and midwifery models of care.

The medical and midwifery models of care

Wagner (1994) identified two views of childbirth: the medical and social models of care. Midwifery aligns itself with the social model of care. He believes that neither model should be seen as right or wrong, and that elements of both should be considered to address different health issues. According to Wagner (1994), the medical model views birth as a medical problem, with “a high risk of pathology, disability and death” (p.30). It also views the pregnant body as a complex machine, and medical intervention as necessary to correct malfunctions of birth (Papps & Olssen, 1997; Wagner, 1994).

Wagner (1994) believed that the dilemma relates to the care of mother and baby, because the interests of the mother may conflict with that of the baby. He argues that obstetricians have altered their allegiance to the rights of the unborn or newborn baby, negating their allegiance to the woman. Wagner (1994) points out that in the social model, pregnancy and birth are not an illness. The woman may not necessarily be a patient, and not all women need medical or surgical procedures. He suggests that those

who hold a social view believe that the medical model have turned birth into a “mystery requiring expert control” (p.32). Within the social model, it is accepted that birth and death happen to everyone. Birth is a biosocial process, linked to how women and childbirth are perceived within society and in a culture (Wagner, 1994).

Katz Rothman (1991) believed that the medical model arose out of a patriarchal society where men developed the profession of viewing women’s bodies, which coincided with industrial society’s development of technology. She also identifies that in the medical model of care, the body is a machine that needs to be fixed. Problems are technical, requiring technical solutions, and the mind and body are separate. Close observation through medical control is required for prevention of problems. Within the medical model’s view, the belief is that only by following this process can one ensure a safe mother and baby.

Donley (1998) contended that the medical model altered behaviour and belief systems in society through perpetuating fear of what might happen if women gave birth without technology. Intervention is used to ensure the outcome of the perfect baby. Conversely, midwifery is considered to be more integrated or to have a holistic approach and is more reflexive (Katz Rothman, 1991). Whereas the medical model only declares a birth normal in retrospect, the midwifery model assumes normality unless proven otherwise (Donley, 1998; Downe, 2001; Murphy-Lawless, 1998; Oakley, 1989; Wagner, 1994).

Within the midwifery model of care there is a belief that women’s bodies are designed to give birth, whereas in the medical model women’s bodies are imperfect, needing control and monitoring (Katz Rothman, 1991; Mander, 2002; Rooks, 1999). Midwifery assists women to give birth, as opposed to the obstetrician delivering babies (Rooks, 1999). Midwives assist women to make their own decisions in a partnership, as opposed to the view that the physician is the key decision-maker (Guilliland & Pairman, 1995; Rooks, 1999). Health and safety of the mother and baby are important within both the midwifery and medical models of care (Rooks, 1999). However, health and safety are not the only goals of midwifery care. Midwives believe that a woman’s childbirth experience is not only physical, but also emotional, social, cultural and spiritual. Childbirth should be a positive transition to motherhood.

Crabtree (2002) as outlined in chapter one, hoped that by exploring the practice of nine New Zealand LMC midwives she would find “normal birth” in its wholeness because of the claim that continuity of care protects the normal birth process. She found that midwives are still influenced by the dominant medical model. It is important to recognise though that not all doctors practise strictly within the medical model, in the same way that not all midwives practise within a midwifery model of care (Katz Rothman, 1991; Rooks, 1999).

Katz Rothman (1991) has suggested that “Doctors can bring the medical model right into the home...and a midwife can bring much of the alternative, (midwifery) model into hospital” (p.25). Midwives within the hospital setting need to be supported to reinforce the values of midwifery over obstetrics (Kirkham & Stapleton, 2000). Conversely Fawdry (1994) suggested that midwives being responsible only for normal birth is restrictive to midwifery practice, and midwives should accept whatever responsibility is appropriate to their particular level of training, with the needs of the mother as the focus. The midwives in this study care for women with medical and obstetric factors that are no longer considered to be within the realms of “normal”. The midwives recognise there are additional skills required to care for those women considered to be “high-risk”.

Lewis and McCaffery (2000) proposed that both the lack of financial reward and the fear of litigation within America are contributing to a de-medicalisation of childbirth, resulting in a rise in stature and success of midwives. A study by Dickson and Willet (1999) found that most midwives with uncomplicated pregnancies would overwhelmingly aim to have a vaginal delivery themselves, in contrast with the views of female obstetricians who rarely attend uncomplicated birth, and where 31% opted for a caesarean section. This is a telling indication of the different models of care.

Rooks (1999) argued that instead of two separate models of care there is a continuum, with extremes of both models at either end. She suggested that the midwifery model has advantages because of its avoidance of unnecessary intervention during labour helping the process to remain normal. The midwifery model addresses the needs of the woman

“not adequately met by the medical management when it is practiced without its complement – midwifery” (p.7). The quest to improve services to women within developed countries such as New Zealand is to seek a balance between those that truly require medical assistance and technology and those that do not (Calvert, 2002). The influence of technology and interventions perpetuated by the medical model on “normal birth”, as well as the advent of risk management, will now be discussed further.

Technology, intervention and normal birth

A high level of intervention means that for many of women birth is not a “normal” healthy physiological process (Banks, 2000). Lowis and McCaffery (2000) compared childbirth in traditional societies with westernized society and found that both societies have some form of intervention to cope with circumstances of difficult labour. This suggests that deviations from normal do occur and traditional systems adopt their own strategies to deal with problems during childbirth.

Naisbitt, Naisbitt and Philips (1999) observed that since post World War Two there was a quest for the creation of technology that would assist to alleviate human suffering. They point out that the development of technology has become so all-pervasive that it is hard to see. They also believe there are good and bad consequences to technology: it is not neutral. Naisbitt, Naisbit and Philips (1999) refer to all technology within the world, but it also seems pertinent to the technological advances within obstetrics affecting midwifery and normal childbirth. Technology in obstetrics such as ultrasound, forceps, ventouse, the cardiotocograph (CTG) machine, fetal scalp electrode, anaesthetics for epidural analgesia and caesarean section have all become familiar in main stream society. Obviously, no one denies that for some women in childbirth, medical care and technology is essential to their survival (World Health Organisation, 1996).

Medico-legal pressures and defensive practice has been described as the reason behind intervention, including an increasing caesarean section rate. Johanson, Newburn & Macfarlane (2002) argue that most obstetric cases in the United Kingdom relate to the labour ward and “failure to intervene or a delay in intervention”. Public expectation has changed and there is a belief “that most if not all deaths could have been prevented”. They also point out that few cases are brought to court “because of unnecessary

intervention” (p. 893). Dallenbach (1999) suggested that the medical model is more supported by the political and legal institutions of our society. Despite claims that 85% of women should be able to give birth without intervention (Donley, 1986; World Health Organisation, 1996) the use of technology has become common practice.

The influence of “Risk” upon birth

The risk scoring system was designed to identify those at high or low risk of problems in pregnancy and labour, to determine where a woman should give birth and the type of care she receives. Determining “risk” is related to identifying factors that may have an increased risk or adverse outcome for mother and baby (Enkin, et al., 2000).

Katz Rothman (1991) stated that if a woman is healthy and normal “She will be classified as low risk” and that “This is just what contemporary medicine has done to pregnancy. It has distinguished between ‘low risk’ and ‘high risk’ pregnancy with the emphasis always on risk” (p.132). “Risk” implies that childbirth is dangerous and must be medically controlled and requires medical intervention (Donley, 1998; Oakley & Houd, 1990). The New Zealand College of Midwives (2002) recognises that although pregnancy and childbirth is a normal life-stage event, there should be additional care available for those women that require it. Skinner (2003) suggested that “risk” and increased intervention has contributed to medico-legal action.

When considering “normal birth” Skinner (2003) noted that “Midwives are faced with a significant paradox in attempting to work in a ‘birth is normal’ paradigm within a ‘birth is risky’ context” (p.4). She believed that there needs to be a new way of dealing with risk and its consequences. She raised many questions that require future research in relation to “risk” and its effect on normal birth, women and midwives. As an example the referral guidelines of the Ministry of Health’s Section 88 (2002) indicate when a midwife should refer a woman for obstetric consultation, thereby identifying women at “risk”. Skinner (2003) questioned whether this can lead to increased “obstetric consultation rates and intervention rates?” (p.7). Crabtree (2002) and Skinner (2003) found that requiring midwives’ to refer to an obstetrician for consultation is one way that increased medicalisation contributes to increased intervention.

Unfortunately for a number of women and babies in non-western countries do have adverse outcomes (Duff, 2002). However, this morbidity and mortality has been used to sanction risk assessment in the provision of maternity services without addressing social and psychological factors (Oakley & Houd, 1990).

I have shown the literature to highlight the fact that medical technology and interventions have influenced “normal birth”. The assessment of women for risk factors has also influenced how “normal birth” is perceived. Midwives have been influenced by these developments, but there is a need to focus on women as individuals (New Zealand College of Midwives, 2002). New Zealand Maori were also affected historically in relation to medicalisation, along with the migration of people from the Pacific Islands. These influences are now considered.

Maori experience and cultural influences

Currently the greater Auckland region has a great variety of different cultures. This is an important fact, as the participants in this study often refer to the cultural norms of the women for whom they care. One of the main tertiary hospitals has a larger Maori and Pacifica population, and the other an increased Asian population (New Zealand Statistics, 2001; Ministry of Health, 2004). Maori and Pacific women are the most likely to have a normal vaginal birth, and Asian women the least likely. European women are the most likely to have an elective procedure, and Maori and Pacific women least likely (Ministry of Health, 2004). This seems apparent in the spread of the population throughout the Greater Auckland region, which includes Counties Manukau. Sadler, McCowan and Stone (2002) found that Maori and Pacific women had lower rates of all obstetric interventions including induction of labour, prelabour or elective caesarean, and operative vaginal delivery, although caesarean rates overall were not different for Maori and Pacific women. Johnson, Lewis and Ansell (1996) found in their study that a high proportion of New Zealand Maori and Pacific Island women contribute to a low intervention rate.

Historical changes to childbirth within New Zealand have greatly affected Maori, the indigenous people of New Zealand (Tupara, 2001). Maori women gave birth traditionally in a birth house separate from their dwelling. They were assisted by older

women of the whanau (family), and husbands were usually present at the birth (Mikaere, 2000). However, European settler influences meant that there was a gradual shift to the doctor and hospital (Papps & Olsson, 1997). In 1907 the Tohunga who cared for the spiritual wellbeing of Maori were outlawed by an Act of Parliament (now repealed), effectively making it more difficult to practise the traditional birth customs (Broughton, 1984; Papps & Olssen, 1997). Ramsden (2001) identified that Maori families were desperate due to high infant mortality rates, as a result of introduced diseases and the Act was introduced to prevent Pakeha (non-Maori) and Maori selling ineffective “cures” (p.25). Historically, the introduction of this Act caused much upset and distress.

Maori women were not really pressured into integrating into the national system until the 1930’s, after which time the traditional birth attendants became less experienced, as nurses and doctors encroached on their childbirth customs and practices. In 1962 the Maori and Pakeha (Non-Maori) rates of birth were equivalent, but before then more Maori gave birth outside of hospital (Mikaere, 2000). Maori women also lost their own customs and traditions of childbirth through hospitalisation (Fox, 2000; Mikaere, 2000). Ramsden (1997) indicated that there was a view that service provided would fit everyone and that the “condition” was nursed rather than the person. Gardiner (1997/1998) described, as an example, the loss of Maori custom in relation to the placenta, and how it was and is important for the “whenua” or placenta to go back to the earth to nourish the baby and life. Today it is common practice in the hospital where I work to recognise the spiritual significance of the whenua and ask all parents if they wish to keep the placenta.

Within the medical model the mind and body are split, and seen as separate from each other or compartmentalised. This goes against the spiritual beliefs of the Maori people. This was because there was a failure to address the psychological issues that went along with different diseases (Oakley & Houd, 1990). Maori believe that the mind and spirit are linked to physical wellbeing, along with the importance of the environment and whanau (family) (Kupe-Wharehoka, 2000; Mikaere, 2000; Rimene, Hassan & Broughton, 1999).

The historical loss of birthing traditions, place of birth and Whanau support affected Maori core cultural beliefs and practices (Fox, 2000). Fox (2000) identified that at a time when Pakeha (non-Maori) women are questioning medicalised childbirth, birth for many Maori has become almost institutionalised and fully integrated into the health system of western medicine. Maori women are also encouraged to birth in hospital because of lower socio-economic conditions and related poor health, diet, excessive stress, and poverty (Donley, 1998; Fox, 2000). Many Maori women, however, are now seeking childbirth that follows traditional Maori custom, which is a natural event at home with support of the Whanau (Kupe-Wharehoka, 2000). If not a home birth then they might seek an environment that is conducive for Maori women and their whanau (Rimene, Hassan & Broughton, 1999).

Fox (1994) believed that Maori should be able to receive safe traditional birthing from Maori midwives, noting there were only 67 Maori midwives within New Zealand at that time. Mikaere (2000) pointed out that it is important not to presume what Maori women want, as they are as diverse as any other population. Tupara (2001) reinforced this by identifying the need to consider the range and diversity of Maori realities within midwifery. Midwives and other practitioners should be prepared for different cultural expectations and requests (Mikaere, 2000).

Pacific culture

Donnelly's (1992) study explored the experiences of 50 Samoan women and compared it to a larger cohort study of 248 Samoan women who gave birth in Wellington between 1985-86. She found that Samoan women in Wellington at that time had a higher caesarean rate than in their own country, and also in comparison to other cultures, possibly due to the larger size of their babies, most of whom weighed more than 4500g. She also found that through migration there was a loss of family support, and this perpetuated a belief that hospital was the safest place to have their babies. Samoan women believed that inner strength, bravery and self control in the face of pain was important. However, the advent of medical interventions such as induction of labour, artificially rupturing the membranes and augmentation, meant that Samoan women often needed to have pharmacological pain relief in the form of Pethidine and epidurals.

The midwives interviewed in this study care for women from different cultural backgrounds. The literature identifies that historically there were different perceptions of “normal birth” within Maori and Pacific cultures. The literature also identifies that the dominance of the medical model and hospitalisation of birth has also changed what “normal birth” means for different cultures. Further, cultural differences could have an influence on how the midwives approach the care for these individual women, as cultural safety is an integral part of their clinical practice (New Zealand College of Midwives, 2002).

Midwifery and “Normal birth” within the current context

Midwifery practice within a secondary care setting is currently influenced by the existence of medical and midwifery models of care. Keeping birth normal, within this setting with little or no intervention, is not easy. Savage (2002) points out that one in five women in New Zealand will start or end their labour in an operating theatre with a caesarean section.

The World Health Organisation (1996) outlined that in childbirth there should be the least possible amount of intervention that is compatible with safety. Therefore there should be a very valid reason for interfering with the natural process. Page (2003) suggested that to keep birth normal midwives need to support women to birth without unnecessary interventions and to control the number of interventions a woman receives within the hospital setting. Roberston (2002) stated that, “defining good midwifery practice is probably as difficult as defining ‘normal birth’ given that birth is a highly individualistic journey for every woman” (p.17). Birth is not an illness and “good midwifery” is about enabling and facilitating the journey of birth by being flexible and open to an individual woman’s needs. She suggested that to keep birth normal, women should be cared for in community based settings. However, she also suggested that until this shift happens there should be justification for all interventions, in terms of benefit and risk.

Page (2003) identified a number of ways to reduce the rate of interventions and caesarean sections in hospitals. Firstly, through the provision of home births and one-to-one care for all women in labour, support and mobilisation. Secondly, encouraging

vaginal birth after caesarean section and offering external cephalic version for breech presentation. Thirdly, the avoidance of continuous electronic fetal monitoring (CTG) where pregnancy is normal, and the use of fetal blood sampling where the CTG indicates abnormality. This is supported by Thacker, Stroup & Chang's Cochrane review (2001) who also found that the routine use of electronic fetal monitoring in low risk women increased the caesarean section rate. Augmentation of labour where there is failure to progress, or labour dystocia, has also been suggested as a way to reduce the caesarean section rate.

Midwives working in secondary care settings look after women with high and low risk pregnancies. However, with regards to intervention Tew (1998) believed that there is little distinction between the two, because many midwives work under the supervision of obstetricians and therefore birth is medically managed. She argues that there is no evidence to suggest that obstetric management makes childbirth safer for those women deemed to be at high or low risk. To help reduce intervention and promote normal birth outcomes Stafford (2001) advocated that midwives should be placed at the forefront of maternity care. In New Zealand, a midwife is nearly always constantly present, even if a doctor attends a woman in labour (Guilliland, 2002).

Midwives are educated to practise without involvement from obstetricians in the majority of cases and Stafford (2001) recognised that “controlling influences from the medical profession continue to undermine midwives’ opportunities to learn, achieve and exercise their full professional role” (p.46). She suggested that midwives be encouraged to keep birth normal through midwifery-led care and practising autonomously, being responsible for medical referral only when necessary. In this way childbirth could be assured to happen with the least amount of intervention. Warwick (2001) asserted that midwives have a responsibility to examine their role in relation to the rising caesarean section rate. Within New Zealand, statistics show differing caesarean section rates in different DHB facilities as previously discussed (Ministry of Health, 2004).

Gould (2000) explored the view of ten midwives from a radical midwives group primarily concerned with promoting natural childbirth. She undertook a concept

analysis of “normal labour”. She believed that doctors have defined birth as abnormal, which has allowed the medicalisation and intervention of childbirth because midwives have failed to define what is normal. Gould found that physiological or natural childbirth is not necessarily the same as normal childbirth because the midwife participants found that the presence of some interventions did not necessarily put women into the category of “abnormal labour”, suggesting that some interventions may be necessary for birth to progress. Thus Gould’s study raises questions about the role of midwives and their care of women in what is deemed to be “normal” or “abnormal” labour.

Savage (2003) has proposed that there be a separate role for the primary and secondary care midwife in Great Britain. This separate role is almost in line with primary and secondary care provided in New Zealand. Midwives working within the hospital environment mostly serve women who require high-risk care. These “core midwives” practise very proficiently within a certain context of care (Manchester, 1998). However, the debate, is that hospitalised birth has “a profound effect on midwives” (Beech, 1998, p.2). Beech (1998) said “Instead of being ‘with women’ they become ‘with-machine’ and spend time trying to mitigate the adverse effects of technology controlled by doctors” (p.2). Strid (1987) supported this claim, and feels that the midwife within the hospital was, and still is in some places, confined to nursing duties or battling to reduce the level of interference on behalf of the women.

Oakley (1989) believed that for women to have a satisfying birth outcome, access to information is a key factor because this helps women take control of their birth. Kitzinger (2002) recognises that there are women who think too much fuss is made about the birth experience and “feel more secure knowing that childbirth is being managed by a top obstetrician with skills to augment or replace the natural process. Women should be able to have what they choose in childbirth” (p.7). Warwick (2001) also suggested that our wider culture has the view that there should be customer choice and easy convenient options available; for example, Page (2003) noted that some women want to have the right to choose a caesarean section. Duff (2002) makes the suggestion that normal birth is “a birth that the mother thinks is normal” and is woman centred (p.313). Many women may have had some form of intervention, but as long as

the intervention was deemed appropriate by all those concerned including the woman, her partner and her carers then birth may be considered normal.

The experiences of midwives are directly linked to the women for whom they care. The New Zealand College of Midwives (2002) handbook for practice outlines that “Continuity of midwifery care enhances and protects the normal process of childbirth” (p.3). However, the New Zealand statistics continue to show increased intervention despite the provision of continuity of care (Ministry of Health, 2004). Midwives within a secondary care setting are working within a fragmented care model and their birth outcomes are also variable. Although in some secondary care settings, normal birth outcomes (with those providing fragmented care) are comparable or better than those providing continuity of care (Ministry of Health, 2004).

As stated previously in Chapter One, the majority of women in New Zealand give birth to their babies within a secondary or tertiary facility. It has been argued that the place to birth normally without intervention is not within the hospital environment (Banks, 2000; Kitzinger, 2002; Tew 1978). However, it is important to explore how midwives adapt to this environment, and whether a midwifery philosophy of “keeping birth normal” is evident even if they are surrounded with the medical model. Warwick (2001) believed that midwives need to examine current practice and their role in promoting “normal birth”. She also states that midwives need to ensure that the hospital environment does not “work against women” and promotion of “normal birth” (p.155).

Summary

“Normal” can have different meanings within different contexts. The notion of “normal birth” has changed through historical, social, cultural and political influences over time. Historically, midwives struggled to maintain their role in regards to childbirth through male domination and medicalisation. The obstetric profession took control over the management, location and provision of care to women throughout the childbirth process, to the detriment of the midwife and GP. Many women believe hospital is the safest place to give birth. Although the scientific evidence does not support this belief, it is now firmly entrenched within society. Historically, Maori and other cultures within New Zealand were influenced by changes to childbirth practices and the medical view

of birth. Women who may have had a “normal birth” also might have had some or many forms of medical intervention and might require some form of pain relief.

Midwifery and medical models of care co-exist especially within secondary and tertiary care settings. Within the medical model birth is risky and only normal in retrospect, whereas within the midwifery model birth is normal unless proven otherwise. Risk management is the cornerstone of obstetrics and perpetuates fear, the need for technology, surveillance, monitoring and intervention. Many midwives in secondary care settings are faced with the provision of care to women dominated by the medical model. However, it is important for midwives to work with a women centred approach to achieve a birth experience that is acceptable to women themselves and midwives should be encouraged to explore how they can try to “keep birth normal”.

CHAPTER THREE

Research Methodology and Method

Introduction

In this chapter the research methodology and method are discussed. This qualitative study was conducted using van Manen's (1990) research method. The philosophical underpinnings of his human science research uses a hermeneutic phenomenological approach and includes the employment of thematic analysis. In this chapter I will outline the process I undertook to ensure trustworthiness or rigour of this study. Ethical considerations, recruitment of the participants, consent, anonymity and confidentiality are discussed. I also give an outline of the participants, and indicate my concern for them, as well as the care I have taken as the researcher in the gathering the data. I present the process of identifying themes and the key to data interpretation. Alongside this I will show how my understanding was enhanced by obtaining feedback on the data analysis, and how I addressed uncertainties that arose during the research process.

Research Methodology

Qualitative research was chosen to answer the research question. The research question meant that the study needed to focus on human experience as it is lived. This led the researcher (me) to deal with the issue of human complexity by exploring it directly (Polit & Hungler, 1997). van Manen's (1990) hermeneutic thematic analysis research method is a set of methodological suggestions for engaging in human science research and writing. It was therefore deemed an appropriate tool to answer the research question. Thematic analysis, according to van Manen (1990), involves reflectively analysing the structural or thematic aspects of a particular experience: a means to get at the notion being addressed. There is concern that theme analysis is some mechanical way of coding transcripts or texts. However, van Manen (1990) sees theme analysis "not as a rule bound process but a free act of 'seeing' meaning". Themes are seen as "structures of experience" (p.79). The intention of this study is to gain some insight into the midwives' everyday experience of keeping birth normal in a secondary care or hospital setting. How one gain's insight into the experience of the participants translated

into human science research texts is by reading and writing and re-writing texts which invite dialogue with those who interact with the text in a subjective way (van Manen, 1990). As van Manen (1990) stated “Subjectivity means that one needs to be as perceptive, insightful and discerning as one can be in order to show or disclose the object in its full richness and in its greatest depth” (p. 20).

Philosophical underpinnings

The philosophical approach that has directed this study is van Manen’s (1990) method of hermeneutic thematic analysis. van Manen (1990) stated: “The notion underlying this approach is that interpretive phenomenological research and theorising cannot be separated from the textual practice of writing”(p.x). How does this research methodology fit with the research question? He says: “Hermeneutics and phenomenology are seen to be involved in all disciplines of the humanities and social sciences that interpret meaningful expressions of the active inner, cognitive, or spiritual life of human beings in social, historical or political contexts” (p.181). Hermeneutics was originally the science of biblical interpretation, which later was brought to other texts (Crotty, 1998). It therefore appeared this was an appropriate methodology that fits with explicating meaning from the texts of life (van Manen, 1990). This was further reinforced by the fact that many midwives and nurses have used the philosophy of hermeneutics to inform interpretive research (Draucker, 1999; Hunter, 2000; Smythe, 1998). Understanding and interpretation is the primary focus of hermeneutics (Crotty, 1998; Geanellos, 1998). However, Geanellos (1998) cautions that there are methodological implications regarding hermeneutic philosophy use in qualitative research in relation to:

- (i) the need to address forestructures and pre-understandings;
- (ii) checking interpretations with research participants;
- (iii) seeking objectivity consensus and accuracy in textual interpretations;
- (iv) evaluating interpretations and
- (iv) gaining entry into the hermeneutic circle (p.154).

van Manen (1990), referring to Heidegger’s notion of hermeneutics, stated that Heidegger’s understanding “was not aimed at re-experiencing another’s experience but rather to grasp one’s own possibilities for being-in-the-world in certain ways. To

interpret a text is to come to understand the possibilities of being revealed by the text” (p.180). Heidegger’s (1927/1962) philosophy as presented in his work *Being and Time*, is an exploration of into the “meaning of being”. Heidegger uses the German word “Dasein” which in essence means, “to be” or “being”, although it is more complex than that because the English word fails to correlate with the German original (King, 2001). Meaning in Heidegger’s sense, is that from which something is understandable as the thing it is (King, 2001). To understand the thing as it is, we are called to live in awareness and consciousness. Yet much of what we do is often around everyday skillful coping rather than living in such a state of awareness. Heidegger sees “Dasein” as the human way of “being” as it arises in the midst of our practical affairs in “our average everydayness”. Heidegger argues that humans are always living hermeneutically. Human beings find significance and meaning in their worlds and it is in this way that researchers and scholars can come to a deeper understanding of the notions or the thing in itself through studying (Draucker, 1999, p.361).

Hermeneutic circle

The notion of the hermeneutic circle as outlined by Crotty (1998) is to “understand the whole by grasping its parts and comprehending the meaning of the parts through divining the whole” (p.92). Schleiermacher used the hermeneutic circle as a metaphor for seeking understanding within the parts and whole of texts. He believed that the hermeneutic circle represented “the art of understanding” (Annells, 1996). Heidegger gave the hermeneutic circle meaning of his own, and linked it to his notion of “Dasein” or being and fore-structures or “existentials”: structures of being that make human existence and behaviour possible, to form “a circle of understanding” (Crotty, 1998, p.98). Heidegger described hermeneutical phenomenology as a circular movement. We begin from a pre-understanding of being and in our quest for being we “unfold a rudimentary understanding and render explicit and thematic what is at first implicit and unthematized” (Crotty, 1998, p.97). Therefore the process of transcribing the interviews into text and coming to some deeper understanding of the participants’ experiences, and then organising the text into themes, was undertaken.

In this study, during the analysis of the text, all understandings are taken back to all previous understandings, and taken forward to the possibility of all future

understandings. They are not fixed. They all become part of a dynamic, complex, ever-changing, never-quite-understood whole. It involves coming to a deep understanding and yet knowing there is still more to be attained and understood (Smythe & Spence, 1999). As a researcher I moved from overall interpretation of the text to significant parts of the text and back again. Koch & Harrington (1998) asserted that getting into the hermeneutic circle properly relies on a person's background. The participants and the researcher cannot assume a privileged position in interpretation. Participants, who already have pre-understandings, tell their stories, and the researcher can only make explicit what is already understood in their background and pre-understandings. To gain understanding within the hermeneutic circle the researcher moves between the participants' experiences transcribed into texts, and the shared meaning between the parts and the whole of the texts.

Existentials or lifeworld themes

Heidegger, as interpreted by King (2001), uses "existential" as a term that applies only to humanity's being, and to the inquiry that has humanity's being for its theme. The enquiry is existential because it takes its lead from the essence of being human, which lies in one's existence. King (2001) sees "existentials" as details in the whole that cannot be detached from the whole, but can be discerned and defined within it as essential to it and helping to make the whole as it is (p.43). The world of lived experience is complex, and the way it is interpreted can be different in different lifeworlds. The lifeworld experience of a midwife is different from that of a researcher or mother, and yet we may experience different life worlds within a single day, by being at work or at home (van Manen, 1990). Existentials are a way of giving structure to the meanings of lived experiences and being-in-the-world, and how reflectively they can be described and interpreted.

As stated previously, existential or lifeworld themes are van Manen's (1990) way of exploring the human lifeworld or the world as it is lived in everyday situations and relations. The lifeworld is complex, meanings can be interpreted differently by different human existence and reality. However van Manen (1990) identified lifeworld themes that can be fundamentally the same, regardless of the specific lifeworld in which a human being is situated, even historically, culturally or socially. Heidegger used the

word “existential” to denote the understanding that each of us has of our concrete existence and of all that belongs to it (King, 2001, p.46). van Manen (1990) used the word “existential” and does so in the sense defined by Heidegger. The four lifeworld existentials of lived space, lived body, lived time, and lived other guided the process of questioning, reflecting and writing used to carry out the analysis in this study.

Lived space or spatiality is space as it is felt. In other words, space can sometimes affect the way we feel and different spaces might have different significance. In giving birth, a woman will probably require a space that feels safe and secure, a space to feel comfortable or intimate. The social and cultural character of space has an influence on experiencing the space. “Being” in the space known as the hospital where people go to give birth may have different memories or recalled experiences for different people. van Manen (1990) also talked about distance as it is experienced, and how it may be different from actual distance. Travelling to the hospital in labour may be short in measured distance but it may feel like a long way if the woman is in strong labour and the road is bumpy. van Manen referred to lived space as “a category for inquiring into the ways we experience the affairs of our day to day existence” (p.103). The places and spaces in which we spend time, such as our home and professional or workspace, help to shape our everyday experiences in our lives.

Lived body or corporeality is how our physical body or presence reveals or conceals something about ourselves. Another may see our body as awkward or beautiful, depending on the situation. When a midwife greets a pregnant woman the woman knows the “normal” feel of her body. The midwife’s hands know what to do to examine a pregnant woman’s abdomen, feeling the abdomen for size and the position of the baby hidden underneath. The midwife’s eyes see the woman’s body and the ears hear the woman in labour and perhaps even the midwife can smell if there is liquor present, or the membranes have ruptured. The gut-feeling of the woman or the midwife may indicate satisfaction, or perhaps concern that all may not be well. We are always bodily in the world, our bodily presence unconsciously revealing and concealing something at the same time (van Manen, 1990).

Lived time or temporality is time as it is lived, not time by the clock, but subjective time that seems to speed up or slow down depending on what is happening in our lives. For the midwife trying to keep birth normal it may mean ignoring time to give the woman more time to progress before intervention takes place. The context within which the core midwife practices, creates expectations that at a certain time particular interventions will occur. van Manen (1990) also talked about historical time: what has gone before in our history comes along with us and influences the present time because our past has helped to shape who we are and will in turn influence our future. “Past, present and future constitute the horizons of a person’s temporal landscape” (p.104). It might mean the last experience the midwife had with a woman with a similar history in labour influences how she responds to this woman in labour and her ability to keep birth normal.

Lived other, or human relationality, according to van Manen (1990) referred to the way we relate to “others” in the world. We may have an impression of the other that may be different from others’ perceptions. The “lived other” sometimes creates meaning of our experiences in a social sense. Being in the world is being-in-the-world with others. The sharing of ideas or different views of others can affect our own view of the world. Heidegger talked about this in terms of “thrownness” as a being that is already in the midst of other beings, thrown into a world that already is (King, 2001, p.56). Sometimes the woman, and her expectations of pain in labour and normal birth influence the midwife. A request might be made for an epidural or an elective caesarean section. The woman’s ideas or views have already been formed by others. Sharing the hospital environment with other medical practitioners also influences the midwife in a secondary care setting. The midwife might be obliged to act upon decisions that have already been made regarding the woman’s care, or by being involved with inducing labour. Perhaps the “lived other” is multi-layered. The midwife responds to the “other” in caring for women, while also responding to “other” in relating to medical personnel.

Pre-understandings

Husserl, under whom Heidegger studied in Germany, designed the concept of bracketing as a way of excluding researchers’ bias from a study (Koch, 1995). Heidegger questioned this philosophical approach (Koch, 1996; van Manen, 1990). van

Manen (1990) believed that the problem with studying any phenomenon is that we know too much about that which we wish to investigate. He argues that if we ignore what we already know, our presuppositions can creep back into our reflections. van Manen (1990) stated, “It is better to make explicit our understandings, beliefs, biases, assumptions, presuppositions and theories” (p.47). Heidegger made clear that we only understand in terms of what we already know, because if we did not, then there would not be any understanding (Genellos, 1998). Our understanding is shaped from our past and present and is ever developing.

My being-in-the world leads me to agree with Heidegger and van Manen in that I am already “born” into a world of meaning and understanding, which cannot be eliminated because it “already is”. This pre-understanding influenced me as a researcher because I am a midwife employed within a secondary care setting, that is part of this study. I am working in the environment and experiencing the setting for myself. I am also aware of my opinions about certain influences that could affect normal birth: for example, the medical and midwifery models of care. Therefore, in Chapter One I revealed my background and outlined my presuppositions.

Method

Introduction

The intention of this study is to bring to light midwives’ experience of keeping birth normal while working within a secondary care setting. I interviewed “core” midwives, or midwives employed to work in secondary or tertiary hospitals, to explore their interpretation of “normal birth”. The interviews were conducted to gain a deeper understanding of the influences on their everyday practice to achieve “normal vaginal” births. The purpose of this methods chapter is to describe the process of the study so as to enable the reader to follow the methods for obtaining, organising and analysing the data for the research. In line with van Manen’s (1990) human science research approach the participants were interviewed to gain rich and deep data to understand the meaning of their experience. The participants anonymity has been protected throughout the study. Issues of rigour and trustworthiness of the research are also discussed.

Ethical considerations

When I was considering the ethical aspects of this study, I was aware that it was important to carry out the research in such a way as to ensure that the midwife participants gave informed consent. This includes the participants being fully aware of the purpose of the research and what was expected of them. It was also important to safeguard their privacy. I endeavoured to take the appropriate steps to remove or prevent harm to the participants and to ensure that the benefits of the research outweighed any risks. These aspects will be discussed further in the “concern for participants” subheading within this methods section. The participation of human subjects within any research, and certainly if one is researching lived experience, means that care must be exercised in ensuring that the welfare of the participants was protected (Polit & Hungler, 1997). Ethics approval for this study was obtained from Auckland University of Technology Ethics Committee (AUTEK) in April 2002.

Recruitment of the participants

The point of reflecting on other people’s experience is that they allow us to become more informed, shaped or enriched by revealing the full meaning of their experience (van Manen, 1990). The selection of participants was through purposive sampling and snowball or nominated sampling in order to meet the aim of this study: to explore midwives’ experiences of keeping birth normal while working in a secondary care setting. Purposeful sampling is “selecting the best informant who is able to meet the informational needs of the study”, and “who is articulate, reflective and willing to share with the interviewer” (Morse, 1989, p.117). Sample size in qualitative research, according to Sandelowki (1995) is a matter of judgement and experience in the following: evaluating the quality of the information collected against the uses of which it will be put; use of the particular research method; and purposeful sampling strategy employed. She says that an adequate sample size in qualitative research is one “that permits, by virtue of not being too large, the deep, case-oriented analysis that is a hallmark of all qualitative inquiry. That also results in, by virtue of not being too small, a new and richly textured understanding of experience” (p.183). Eight midwife participants were recruited to participate in this study. This number was decided through discussion with my supervisors and research group and by a sense of having more than enough data.

The first four midwives were recruited through purposive sampling and posted a copy of the participant information sheet (appendix A) and consent form (appendix B), with contact numbers. These participants were known to me. They then voluntarily contacted me by phone to find out more information. After further explanation about the study they verbally agreed to be part of the study. No reply from the midwives would have meant that they were not interested in participating in the study. However they all seemed very willing to participate and while talking with them on the phone I reiterated that if they did not want to participate in the study they had the right to decline.

The fifth midwife was not very well known to me as the researcher. I contacted her by phone because I did not have her postal address. I explained the study and then offered to post the participant information sheet to her. She accepted this and I suggested that if she did want to participate once she read the information sheet she contact me again and then we could discuss the study. A week later she contacted me by phone and verbally agreed to be in the study and was very interested in talking to me. The last three midwives were approached after asking previous participants if they could suggest someone suitable for the study as previously described as snowball or nominated sampling. Snowball sampling is the selection of participants by means of nominations or referrals from earlier participants (Polit & Hungler, 1997). The use of nominated or snowball sampling was a way of making connections with midwives as appropriate participants for the study, who were unknown to myself as the researcher (Lofland and Lofland, 1995). The midwives that had already participated in the study said that they would quite happily approach another midwife that they thought was suitable for the study. They gave them a participant information sheet to ensure there was no coercion on my behalf. Subsequently the midwives gave me the phone numbers of the last three participants. I then telephoned them a week later to see if they were interested in joining the study. I again explained that they had the right to decline but they also seemed quite happy to be part of the study.

Consent

A suitable and mutual time to meet was arranged. Following an explanation of the study, and answering any questions regarding the study, each participant was invited to

sign the consent form (appendix B). The participants were advised that the storage of the consent forms would be separate from any of the data and kept by the primary supervisor on AUT premises in a locked cupboard as required by the AUT ethics committee (AUTEC). The midwives were informed that they had the right to withdraw from the study at any time and remove, delete or add any data that they wished to exclude or include as part of the study until the return of the transcripts. They were all aware that once the data interpretation process had begun it would be difficult to withdraw from the study. This was also reiterated in a covering letter when the transcripts were returned to the participants for their approval. None of the participants deleted any of the data from their research interviews. Some were concerned about the way they spoke and were reassured that their stories would be edited to ensure that they read in a more academic manner. After this reassurance they were pleased for their interview data to be included in the study.

Anonymity and confidentiality

To maintain anonymity the midwife interviews were numbered one to eight on the interview tapes and the tapes were locked in a metal cabinet. Pseudonyms were then used on the transcripts and any data pertaining to the study. Only the primary supervisor and myself know the real identity of the midwives. As mentioned previously, the consent forms are kept separate from the transcripts. The data will be kept for six years and will then be destroyed, in accordance with AUTEC's requirements. Transcribing the interviews myself meant that only I had access to the tapes and therefore did not have to obtain non-disclosure consent from a typist.

Names of the hospitals or secondary and tertiary settings where the midwives work are not identified. The women that the midwives talked about were never identified by name to me. They were referred to as "a woman" or a "young woman" who they were looking after. Colleagues that were mentioned have been referred to as "another midwife" or "the doctor" or "obstetrician" or "registrar". The midwives themselves seemed very conscious of not revealing the names of the people they were talking about. However, if they did share names with me those persons' confidentiality and privacy was maintained by myself to ensure that the participants and those mentioned were protected.

I was also careful not to mention in midwifery circles those midwives that were participating in the study. I had been asked directly who was in the study and I clearly stated that I could not tell them. Two of the midwives revealed to their midwife friends that they were participating in the study but they were aware that I the researcher would maintain confidentiality. I chose to use the external mail system and not the hospital mail system to ensure that the midwives could not be identified as participants of this study.

The participants

The midwives interviewed were all registered midwives employed within a secondary or tertiary hospital within the Auckland region, New Zealand. The midwives ranged from two years registration to those with over 30 years' experience within a delivery suite. Midwives working in delivery suite in a secondary care setting were chosen to gain a deeper understanding of their everyday experiences in regards to "normal birth", in line with the research question. During the period of data collection I worked as a staff midwife; therefore there were no power issues, such as a student and tutor relationship. The eight midwives that participated in the study have been given the pseudonyms Kay, Gabrielle, Sally, Bronwyn, Maggie, Martha, Mary and Sarah. I found they were very willing to share their experiences and there was a conscientiousness to ensure they were revealing experiences that would benefit the research study.

Individuals cooperating in the study play an active rather than a passive role and are therefore referred to as participants (Polit & Hungler, 1997). Koch (1996) suggested that neither the researcher nor the researched can assume a privileged position in interpretation. van Manen (1990) suggested that research participants invest more than a passing interest in the research project. They "begin to care about the subject and the research question so that the researcher develops a certain moral obligation to his or her participants that should prevent a sheer exploitative situation" (p. 98). Draucker (1999) argues that there is a convergence of perspectives of the participants, the researcher and other data sources in the interpretation that result in interpretive findings. This belief was borne out by this study.

Concern for participants

There was no intentional risk involved in this study, although, the participants may have discussed issues that required further counselling. If needed, as stated in the AUTECH ethics proposal, the participants would have been encouraged to seek work-place counselling and support systems via their occupational health service. Those midwives that participated in this study did not indicate to me that they felt they needed counselling during or after they were interviewed. The sharing and reflection of experiences in this study gave the participants the opportunity to discuss their practice, which appeared to be agreeable and have shared benefit. I really enjoyed the interviews, and on the whole the participants appeared to reciprocate an experience that was positive. One midwife did not like the tape recorder and seemed to talk better when it was switched off. I was very aware of this and endeavoured to put her at ease by stopping the tape as many times as was necessary. My primary supervisor commented after the interview that she thought I was very considerate of this participant's feelings. This reassured me that I was concerned that my participants felt comfortable during the interviews.

The participants chose where they would like to be interviewed. I travelled to them to ensure they were inconvenienced as little as possible. I was also aware of not impinging on their valuable time and the interviews were completed in one to two hours. For the most part I took something to say thank-you, for example; a cake or something to drink; although a couple of midwives had made cake for us to share. I did spend time before and after the interviews with the participants discussing different issues and creating a comfortable social environment. As mentioned previously, the participants all seemed to want to give me information that was valuable for the study. They commented on their interviews by saying things like, "I hope that is what you wanted," or "Is that the kind of thing you wish to know?" and they were reassured that the information was very helpful. As the interviews proceeded there appeared to be an ease of interviewing that improved to a social conversational chat, perhaps due to my ease in the research interview process. All the midwife participants were thanked greatly for the sharing of their experiences.

Concerns of the researcher

Working full time in a busy delivery unit I was aware that I had commonalties with the research participants and found that what the midwives were saying was encouraging me to reflect on my own practice and how I saw practice occurring within the unit. I noticed that I was asking more questions about my own decision making and “normal birth”, for example, I would ask myself whether a particular woman needed to be on the CTG (cardiotocograph) monitor. I always believed that it was my role to promote as normal a birth as possible (Earl, et al., 2002). Perhaps researching this topic has made me aware of some of the issues that I had not thought about for a while in the everyday “doing” of midwifery. Talking with my research supervisors and research study group helped me to process these issues as they arose. I feel that this study has been very beneficial to me as a practitioner because it has encouraged me to think more deeply about my clinical practice.

On one occasion, I looked after a young 16-year-old primigravid woman and thought that she was coping really well. When she came in I assessed how she was progressing and her cervix was seven centimetres dilated. So I suggested she mobilise for a while and see how she went. I monitored the fetal heart via intermittent auscultation as the baby was doing well. I decided against offering pain relief to her, and waited until she requested it. I did not want to make her think that she needed pain relief, as she was coping so well. After about two hours she lay on her left lateral side and was becoming more distressed. She then asked me if she could have something for the pain, so I said to her, “would you like to try the gas and air (entonox)?” She agreed, and not long after her waters broke spontaneously and she wanted to push. She then proceeded to have a beautiful delivery of a baby girl in the left lateral position with an intact perineum.

My dilemma came afterwards when I was telling this story to some midwives and students in the tearoom. The student asked me if it was giving a woman choice and knowledge of all her options by not mentioning the different forms of pain relief available. I wondered if I should have told the young woman all the pain relief options. It raised the question that perhaps by doing the research on “normal birth” it had influenced the care I had given this young woman. The College of Midwives (2002) practice guidelines stated that midwives are responsible to the woman and should

“uphold each woman’s right to free, informed choice and consent throughout her childbirth experience. However, the practice guidelines also state that “Midwives have a responsibility not to interfere with the normal process of pregnancy and childbirth.” (p.5). I discussed this with my supervisor and other midwives, and they felt that I had brought the young woman to the centre of her care, rather than taking anything away from her. This is because she decided when she needed something, and I did not coerce or influence her into thinking that she was not coping. I felt reassured by this and knew that the experience the young woman and I had was a special one. I still was very much aware of keeping birth normal. As a practitioner and a researcher I became conscious of the influences that listening to the research participants was having upon me. I also questioned whether my own beliefs were also coming to the fore as well.

Gathering the data

All the participants, except one, chose to be interviewed in their home for reasons of privacy. One participant was interviewed in a quiet room at a hospital, as this was her request. As the primary researcher, I conducted the interviews myself. These were double taped, to ensure there was no loss of data. As van Manen (1990) noted, “sometimes it is easier to talk than to write about personal experience, because writing forces the person into a more reflective attitude, which may make it more difficult to stay close to an experience as it is immediately lived” (p. 67). The midwives were interviewed on one occasion only and the interviews lasted for one to two hours. The interviews were conducted over a period of ten months. Gathering, reflecting and analysing the data was ongoing throughout the research process. I conducted two interviews and then transcribed these myself. Once I had gained a deeper understanding or feeling for the data from the first two interviews. I continued this process for the rest of the interviews.

Initially as a researcher I was concerned that I might not conduct the interviews in an appropriate manner. I wanted to elicit data that was rich, deep, and pertinent to my research question. I remember my primary supervisor telling me to read van Manen’s (1990) excerpt on interviewing to help align my focus on the research question and interview process. Therefore, at the beginning of each interview we talked about the research question. Then, to help the participants relax and focus on the topic I started by

asking them how many years they had been working in a secondary or tertiary setting. I then proceeded to ask them what they thought “normal birth” was. The hermeneutic phenomenological interview serves a specific purpose. van Manen (1990) advised that “the interview process needs to be disciplined by the fundamental question that prompted the need for the interview in the first place” and that it is important not to get “carried away with interviews that go everywhere and nowhere” (p.66-67). I therefore asked the participants if they could recount stories about normal birth or sometimes what they had been doing at work that week. If the midwives didn’t continue talking I would ask; “Can you tell me about a story that you felt really good about?” or “Tell me about a labour or birth that you felt because of your actions the outcome was a normal birth?” I then might prompt the participants by asking, “Can you please expand that a bit more for me?” or “How did you feel about that?” Mostly I was listening and encouraging the participants to share their stories or describe in further or richer detail their thoughts, feelings and actions related to the experiences they had brought up in the interview.

After the first interview with Kay (pseudonym) I felt elated and fearful at the same time, mostly because I had completed my first interview. However, I was concerned about whether or not I had enough stories within the data. I was seeking to ensure that the lived experience of the participant was captured in the stories that had been shared. I journalled my experience and wrote: “The time seemed to go slowly in the first half hour of the interview and then the second half seemed to go really fast, perhaps I was getting used to it.” On re-reading the transcript, and after discussion with supervisors I was reassured that I was on the right track.

The second participant, Gabrielle, was very wary of the tape and I felt she would have communicated better had it not been there (as mentioned previously). I therefore stopped the tape as many times as was appropriate to give her time to think and to put her at ease. I journalled: “The interview didn’t flow as well as the first but I felt that she mentioned a lot of similar things that participant one did,” and remember feeling quite excited by it.

Transcribing the interviews myself meant that I got to know the data in greater depth. van Manen (1990) said our data needs to be oriented, strong, rich and deep: Oriented to the research question, developing the strongest interpretation. He says that when writing and reading text “One must meet with it, go through it, encounter it, suffer it, consume it and, as well be consumed by it” (p.153). The experiences the participants revealed were described in great detail. I was aware that it was important to stay close to the research question and to encourage the participants to give as much detail as they could remember about the experiences that they shared, in order to gain data that was rich and strong in description.

I then began to read and re-read the transcribed experiences and ponder on what they might mean. There were definitely similar notions coming through in the data, even after five participants. Within my research study group it was felt I had good data. However, I continued on to interview eight participants until I felt certain that there was enough data to give the greatest depth, and that they had enough experiences in common.

Analysing the data

Analysing the data is referred to as hermeneutic phenomenological reflection by van Manen (1990). He asserts that “Human science meaning can only be communicated textually,” reflecting on lived experience by “reflectively analysing structural or thematic aspects of that experience” (p.78). Once each of the interviews was completed I read through the transcript to get a feel for the experience and information shared by the participants. I read through each transcript again and again to gain an understanding of the midwives’ experiences, because as van Manen (1990) pointed out, “the meaning of lived experience is usually hidden or veiled” (p.27).

Group supervision was conducted with the supervisors and other midwives conducting research. We met once a month and I shared some of the stories with them. This open discussion enabled me to see different perspectives as to what the experience might be about for each participant, and stimulated me to continue on to discover more. van Manen (1990) referred to the “phenomenological nod” which is achieved by recognising an experience that is described in such a way as to cause us to nod and

agree that we could have had, or have had an experience like this (p.27). van Manen (1990) also talked about research groups and gathering the interpretive insights of others to a research text. Sharing the text with advisors, colleagues or friends can be a way of testing meaning or different interpretations. Discussion of a text may mean there are multiple or even conflicting notions of interpretation, and questions may arise about whose interpretation is the correct one. However, gathering different insights of the texts we are interpreting are a means of getting at the notion, and are about explicating various meanings from human actions and experiences.

I spoke at the Joan Donley Research Collaboration Forum in Christchurch on the 11 and 12 July 2003 and presented three of my stories and some interpretation. The feedback I received was very positive. Several midwives commented that they could relate to the stories and the interpretation that I presented. I also presented one of the stories at a College of Midwives meeting in Auckland. It was identified that there is a great need to share different stories with other midwives in a safe and non-threatening way at future college meetings. I have also presented at the Middlemore, Counties Manukau District Health Board (CMDHB) and Auckland University of Technology (AUT) conference on the 22 October 2003. The feedback I received from the presentation was also very positive and some of the midwives have approached me and shared their thoughts regarding the study. One midwife felt it made her reflect upon her practice and another agreed that the issues regarding normal birth were very complex. Many other midwives said they couldn't wait to read the results of the study. As part of the requirement for completing my thesis through AUT I have also undertaken presentation of my research.

Copies of the transcripts were given back to the participants to review. They made very few changes, except for grammatical errors. There is debate as to whether data should be returned to the participants to validate research. Koch and Harrington (1998) questioned the benefit apart from gaining verbal accuracy. Depending on the method, the individual participant's data may be under many different themes and it may be difficult to identify the participant's contribution. It was therefore decided to return the transcripts, once edited, back to the participants for validation only. Once more in-depth data analysis began it was felt it would be difficult to separate the different data.

The participants were aware that they had the right to withdraw from the study up until this point. No one withdrew from the study.

My research supervisor received copies of my transcripts and reviewed my analysis as it progressed. I began to write and rewrite to grasp the meaning of midwives' experiences of keeping birth normal within a secondary care setting, in the everyday environment where they work. Already I was looking for what the themes might be, to see whether any of the next participants would bring up something similar. Initially I worked on each interview transcript separately, analysing the stories and information within a single interview in relation to the whole. Later, I analysed each interview in relation to the other interview transcripts. Notes were made in the margin regarding what notions were being revealed.

I then thought about the stories or texts in terms of emerging themes. One of the stories was the woman influencing her experience and normal birth outcome because she had refused any vaginal examinations (VEs). However, some of the other stories were more difficult to interpret. At my group supervision meeting we discussed what I had been looking at. The supervisors felt that the story about the woman who refused VE's was the most important one. I acknowledged that it was an important story about keeping birth normal, but I was also interested in another story about a woman who was really close to having a caesarean section, but the woman was determined to have a vaginal birth. The woman still felt that she had a normal birth, even though she had multiple interventions. I believed that it was the woman's determination to have a normal birth that influenced the midwife and medical personnel so strongly to allow her more and more time to follow her own process. This, for me, was just as important as the first story. It was at this point of the analysis I began to question, "What is normal birth, anyway?" and as a result, I began looking at the notion of normal birth, and different ways that the participants interpreted it.

The process of reflection upon the data created by the midwives is one of trying to grasp the essence of the experience by understanding structures of the experiences or themes (van Manen, 1990). The themes developed and evolved over time through reflection and re-reading and re-writing. For example, one of the themes seemed to be about

“being confident” and “giving confidence”. After processing this more, there was something that gives the midwives confidence to keep birth normal, and it is this underlying “belief in normal birth”. The analysis was achieved within the hermeneutic circle by looking at parts of the texts and the whole of the texts. I then started piecing my data chapters together, which were then rewritten as a whole to fully uncover the meaning of the phenomenon.

Throughout the data analysis I was aware of the life world existentials that van Manen (1990) writes about in terms of the lived space, lived body, lived time and lived other. I therefore have chosen to use the life world existentials to extend analysis within the data chapters.

Trustworthiness – rigour of qualitative research

There are certain considerations or steps I have taken throughout the research process to ensure rigour or trustworthiness of this qualitative research study. Koch and Harrington (1998) stated “In the health field, with its strong tradition of biomedical research and use of conventional quantitative methods, qualitative research is often criticised for lacking ‘scientific’ rigour” (p.883). However, there has been a long standing debate that qualitative methods for assessing rigour do not fit with those of a qualitative paradigm (Emden & Sandelowski, 1998; Koch, 1996; Koch & Harrington, 1998; Sandelowski, 1993). The dilemma that seems to plague the assessment of credibility in research findings is the difficulty in satisfying all researchers from different epistemological viewpoints with an appropriate assessment criterion (Avis, 1995).

Koch (1996) outlined three issues concerning the “legitimation of the hermeneutic process”(p.174): The philosophical underpinnings of the methodology, representation, or the participation of the researcher in making data, and rigour or the way in which trustworthiness of hermeneutic research can be established. I have already described previously the methodology and philosophical underpinnings related to this study. As part of the methodology in this study the expectation is that there is an involvement of the researcher within the research through interpretation. With the interpretation of the study comes the researcher’s pre-understandings, which we use to make sense of the

world. The participants that are interviewed also have pre-understandings or are self-interpreting. These are not disguised or eliminated (Koch, 1996).

As the researcher of this study I recognise that the interpretation of the data and the final presentation of the themes is situated within a context of time. Perhaps if another researcher were to study the same topic, in the same way in the future the findings may be different due to historical, social and cultural changes over time. Emden and Sandelowski (1998) pointed out that openly declaring that there are possible differences and uncertainties of our findings in the study is to acknowledge the process of knowledge development. Through my interpretation and working with the data I have come to a deeper understanding of the research question. I acknowledge that other researchers might come to a different conclusion through their interpretation. However, I have engaged with others to be open to different points of view, recognising multiple interpretations (Annells, 1996).

To ensure trustworthiness of the data I have included in the data chapters the texts of the midwife participants, to help clarify and support my interpretation. I also transcribed the interviews myself to ensure verbal accuracy (Koch & Harrington, 1998). The accuracy was further verified by returning the transcripts back to the participants for checking. I was very aware of ensuring that ethical considerations were addressed and incorporated into the study. In the “Analysing the data” subsection I have shown examples of how the data was interpreted. I have also included the process of thematic analysis, reflective journaling, and group supervision or peer debriefing, as well as engaging with the hermeneutic circle.

Presentation of themes

The themes that have been identified are from the texts of experience that the midwives have shared to enable the researcher and reader to come to a deeper understanding of what it means to keep birth normal within a secondary care setting. Excerpts from the participants’ narratives have been included in the data chapters, to verify this interpretation. The next three chapters relate to the themes identified from interpretation of the texts during the data analysis process. They are called “Being a midwife ‘is’ keeping birth normal” and “Stepping back and stepping in” and “Interacting with the

doctors”. Chapter Four discusses the midwifery notions of normal birth in relation to the woman and other midwives, and Chapter Five explores the topic of intervention. Chapter Six explores midwife-doctor relationships, and how this affects the birth process. After the three data chapters, there follows a discussion chapter, which includes recommendations for further research, practice and education.

Key to data interpretation

To enable the reader to follow the interpretation of the data chapters I have provided a key to assist in the interpretation and help the reader and the researcher follow the trail of interpretation in an attuned way. The key to data interpretation proceeds as follows:

- The participants are all midwives and are therefore referred to when appropriate as “she” and “her” or “the midwife”.
- The participant’s pseudonym is outlined in brackets at the end of each excerpt of data i.e. (Bronwyn).
- The participants’ speech is in italics and indented.
- [] are included to clarify an abbreviated word e.g. CTG [cardiotocograph].
- ... indicates edited transcripts.

Summary

The methodology and method have been discussed within this chapter in relation to this research study. The qualitative research approach of van Manen’s (1990) hermeneutic phenomenological thematic analysis was chosen to most suitably answer the research question in this study. By engaging within the hermeneutic circle, and considering the lifeworld existentials and philosophical underpinnings of Heidegger, I have described the process of data interpretation and explicating the notions or themes in relation to the research question. Recruiting the participants through purposive and snowball or nominated sampling is described. To answer the research question the participants needed to have the experience and informational needs appropriate for the study. Therefore midwives working within a secondary or tertiary care setting were sought. Ethics approval by the relevant ethics committee was outlined, and attention to ethics during the conduct of this study was explained.

I have described the method to enable the reader to follow the way that the study was conducted to include obtaining, organising and analysing the data for the research. The data was obtained by in-depth taped interviews, which were later transcribed into text. The process of re-reading, re-writing and interpretation to gain a deeper understanding of the notions being explored were used to explicate the themes within the data. My presuppositions I bring with me were shared and described throughout the method. I recognise that the participants also have pre-understandings and are self-interpreting, as do those in group supervision and other data sources in the interpretation. This has led to a convergence of perspectives; that resulted in the interpretive findings. Attention to rigour or trustworthiness has been addressed. Explanations of symbols used are included to ensure that the reader can follow the shared meaning within the data.

CHAPTER FOUR

Being a midwife “is” keeping birth normal

Introduction

The purpose of this study is to explore the research question, “What are midwives’ experiences of keeping birth normal in a secondary care setting?” The aims of the study are: to identify the midwifery skills that are used to achieve normal birth outcomes; to articulate this midwifery knowledge and experience that enables normal birth; and to examine the influences upon midwifery practice today.

In this and the following two chapters I will discuss the themes that emerged from the data while exploring the research question. I will show the texts of experience shared by the midwife participants to enable the reader to follow the interpretation of the data.

In this chapter I reveal that the midwife participants have different notions of what “normal birth” means. Most of them believe that seeing labour and birth with little or no intervention is part of being able to keep birth normal. The participants also show that they have a fundamental belief that women can birth normally. The historical practice of passing on knowledge and midwifery skills verbally from midwife to midwife is seen as still being important today, and assists the midwives to learn to keep birth normal.

Notions of normal birth

In Chapter One I have declared my own perception of “normal birth” as part of my pre-understandings. Within this theme the participants’ understanding of “normal birth” is discussed. The midwives in the study were all asked to tell me what they thought “normal birth” was, in order to clarify what they meant when they referred to normal birth throughout the course of the interview.

For Maggie, “being a midwife,” means experiencing two different kinds of birth: one without an epidural and one with an epidural:

Normal birth to me ultimately would be a vaginal delivery but that would also cover the labour progressing normally as well. Normal means within a reasonable amount of time, with the woman remaining in control, with a baby that’s happy throughout the labour and delivery. That’s normal to me. I wouldn’t class a ventouse or forceps to be normal. Epidurals are becoming more the norm for me particularly in this setting. Even though I continue to fight the cause, in the sense that I don’t want it to become normal, it increasingly is...I have worked in areas where they didn’t have epidurals, for the first part of my career and that was “being a midwife” to me. It was getting a woman through labour; helping her control this pain that she had and assisting her to do that, empowering her to do it without any drugs. From doing that to what we do now as a midwife is a dramatic change to me. Now we care for women with epidurals and it is very easy to sit there and look at a monitor and a syntocinon drip and ensure that a woman remains pain free. That has become a midwifery role in this setting at the moment (Maggie).

Maggie appears to regret the change in her role as a midwife, and the prevalence of epidurals has changed the way she practises. This impacts upon her perception of normal birth. Van Manen (1990) talked about past experiences influencing the present and the future as time is lived:

Whatever I have encountered in my past now sticks to me as memories or as (near) forgotten experiences that somehow leave traces on my being... yet, it is true too that the past changes under the pressures and influences of the present (p.104).

Maggie says, “what we do now is a dramatic change to me”. She recognises the difference in looking after a woman in labour with an epidural and looking after a woman without one. To her “being a midwife” was getting a woman through labour without analgesia, but with the prevalence of epidurals it has become more common

practice for a woman to have one in a secondary or tertiary setting. She sees the technology of an epidural, however, as something that she is in battle against, “to fight the cause”. Young (2003) identified that “increasing advocacy for intervention undermines the societal perception of birth as an essentially normal event” (p. 10). Maggie does not want epidurals to become normal, but knows that even for herself they are becoming “the norm”.

It also seems important in Maggie’s definition of normal birth for the woman to remain “in control”. Is this reflecting upon the importance of a woman not becoming too stressed by the experience? Or has the prevalence of epidurals meant that midwives now rarely see women screaming with the pain or coping with pain? Hunter (2003) found that the noise women make in labour is not as readily acceptable in a secondary or tertiary unit because of the availability of an epidural (p 245). Or perhaps it means that the woman is following her birth plan to have whatever pain relief she has assumed will direct her experience? There is possibly a greater belief about the importance of the experience for the woman than that of accomplishing a normal birth.

Maggie refers to birth being normal if it is achieved “within a reasonable amount of time”. What is a reasonable amount of time for someone in labour when allowing the normal process to unfold? If the birth is taking too long it is seen as no longer normal and requiring intervention. Has Maggie been influenced as a midwife working within a hospital setting regarding time limits, or does every midwife have an acceptable length of time before she considers labour to be abnormal? Are these time limits the same for all midwives? Maggie identifies that the setting she works in with the prevalence of technology influences her practice, and “being a midwife” has changed dramatically. The ability for midwives to practise normal, low intervention midwifery in large obstetric hospitals seems to be diminishing (Hunter, 2003). Maggie identifies this as an influencing factor for her in her efforts to keep birth normal.

Bronwyn also believes that epidurals have an affect on “normal birth”:

Normal birth to me would be, most deliveries other than forceps ventouse, caesarean, and I probably now would exclude an epidural. But I would accept

syntocinon and an episiotomy... I don't really call it normal labour once you've got an epidural in. For the majority of women it does skew the normal. You can get vaginal births and normal births with the management of an epidural but I think that it's just technology that's overused. An epidural is a bit more than accepting 25mgs of Pethidine or a bit of syntocinon to increase the strength of contractions... what I would call more minor interventions, because epidurals can have a big impact on the labour. I think your management of normal labour goes (Bronwyn).

Bronwyn indicates that there has been a change in perception of normal birth with epidurals, and “normal birth” has been altered in some way. She identifies that the use of epidurals “skews” or puts something off track, twists or distorts normal labour (Cambridge Dictionaries Online, 2004). Therefore she no longer considers labour “normal” once a woman has epidural analgesia. This is supported by Anderson (2000), because of its possible side effects upon natural labour. Bronwyn does, however, accept some interventions. It appears that she accepts smaller interventions, such as a small amount of Pethidine or “a bit of” syntocinon.

Bronwyn talks of the “management” of epidurals as though it is a task that can be performed poorly or well. The word “management” conjures up something that needs to be controlled and requires skillful handling. Arney (1982) discussed the technological advances in obstetrics that have changed birth from something to be “attended”, to something that needs to be “managed” (p.7-9).

In contrast, some other participants express their notion of normal birth:

A normal birth is when a woman delivers a baby vaginally by herself with some encouragement from a midwife or doctor or support people and the baby and mother are healthy afterwards. ...Yes I think epidurals are part of a normal delivery. Epidurals are a good pain relief and I don't think you can class pain relief as causing the birth to be abnormal if the woman has a vaginal birth (Mary).

A normal pregnancy, which hopefully results in a normal labour and a normal vaginal delivery without intervention or sometimes with intervention but without any interference as far as a ventouse or forceps goes (Gabrielle).

I would say a normal birth is an unassisted vaginal delivery so not forceps or ventouse or anything like that. But whether women have an epidural or syntocinon, does not necessarily mean you've not had a normal delivery (Kay).

What is important to Mary appears to be that the woman births the baby herself and the baby and mother are healthy afterwards. She does, however, believe that epidurals are now a part of normal birth, providing that the woman has a vaginal birth. However, if the woman does not have a vaginal birth then is there consideration that the epidural possibly could have influenced the birth to be abnormal? Gabrielle suggests that a normal birth is influenced or affected by a normal pregnancy. She includes the notion of a normal pregnancy and labour as a prelude to a “normal” outcome. This definition, like Sally’s, appears to encompass more than the vaginal birth at the end. It seems to be about the events or process that lead up to the point where a woman gives birth. She does identify that a “normal birth” occurs without intervention. However, Gabrielle and Kay believe that some women have a normal birth with intervention. Even though the woman has had some interventions during childbirth, Gabrielle and Kay still feel that a woman has had a normal vaginal birth as long as she does not have a ventouse or forceps.

Sally shares her notion of normal birth with or without pain relief:

It's more than a vaginal birth. It is a vaginal birth, but it's also getting the best outcomes for the woman and her family. It's [acknowledging] their choices and the process and taking that into account. A lot is women's choice, but I do think you [the midwife] still have some sort of say as to getting them through with or without pain relief: whether they cope with Pethidine or do you think they need an epidural. Or, do the women think they want an epidural, but you feel that they can get through the birth without one. Epidurals can affect normal labour where a woman gets to fully dilated but doesn't push effectively. She then ends up with

an instrumental delivery because she hasn't got so much feeling down there. She is not pushing in the right place. She hasn't got effective pushing in the second stage with an epidural (Sally).

Sally describes a normal birth as being more than a physical process of a “vaginal birth.” What seems to be important is the experience, and the way that the woman and her family feel about it. The New Zealand College of Midwives (2002) stated, “Midwifery practice defines “normal” on a one-to-one basis with women. The process is based on informed choice and informed consent, recognising the individuality of each woman’s pregnancy and childbirth experience”(p.36) as previously outlined in chapter two. Sally acknowledges the choice of women but immediately she balances this with the midwife having some direction: “some sort of say”. It appears that even though the woman has a choice, the midwife may or may not influence the woman if she feels that the woman’s decision can affect the outcome, and perhaps goes against her clinical judgement about keeping birth normal. Sally recognises that there is a dilemma around the choice of pain relief for women, and that pain relief options can have an effect upon normal birth. Is it because when women come to a secondary care unit they know that there is the option of having an epidural for pain relief?

What does Sally mean when she talks about the process? Is it about the woman making decisions with the midwife throughout her labour, and about how those decisions can affect her birth outcome and the woman’s birth experience? The word “process” can be interpreted in many ways. It can be the process of growth, or it can be as time goes on, or it can be as something is constructed (Cambridge Dictionaries Online, 2004). It seems that the time shared between the woman and the midwife, the experience of going through the “process” of labour, and the revelations along the way, all have an effect on both parties.

For Sally, a “normal birth” is more than just the outcome. It seems to also depend on how the woman feels about it, and what her expectations are. Sarah agrees with Sally in that she feels normal birth is related to a woman’s expectations. However, she defines “normal birth” rather differently.

Normal birth is ... a normal physiological process. I think it can be a forceps or a ventouse. There is more than one way to skin a cat...every woman's an individual and she shouldn't be labelled as having an abnormal birth... especially if the delivery method is entirely clinically appropriate for her to have a safe outcome. Yet I don't think...caesarean sections and elective caesarean sections are normal.

She shares how she feels about epidurals and normal birth:

...I think if women are educated, empowered and supported to trust their bodies and work with their bodies, not be frightened and accept that pain is a part of childbirth and it is going to hurt then epidurals don't need to have a place within normal childbirth. Yet, if women's expectations of normal childbirth include a painless experience, then an epidural does come into normal childbirth. For them, epidurals are great (Sarah).

Sarah justifies forceps and ventouse as being part of normal birth, saying that there is more than one way to “skin a cat.” It appears that Sarah thinks any method of vaginal delivery is a normal birth. “There is more than one way to skin a cat,” implies that there are many ways to achieve a birth through the birth canal. Sarah feels it is important that women are not labelled or left feeling they had an abnormal birth. To this end, Sarah accommodates epidural analgesia, forceps and ventouse deliveries within her perception or notion of “normal birth”. Could this mean that the acceptance of intervention has crept in with greater ease so that those women who do have interventions are not undermined or made to feel inadequate? Is there a failure to question whether the intervention will influence the outcome to be normal or abnormal, for fear of affecting how the woman feels about her birth experience, or to justify the intervention? Sarah seems to have absorbed a very medicalised view of normal childbirth from working in her environment. It appears that for Sarah, the outcome of a vaginal birth is not as important as how the woman feels about her experience, and what the woman's expectations are.

To summarise, when asked to define “normal birth”, all the midwife participants delineate the boundaries of “normal birth” slightly differently, within their own “lifeworld” or lived experience of being a midwife (King, 2001; van Manen, 1990). As Sally says, it is about “the process” and the effect of the experience on women. Women’s expectations and choices, especially regarding pain relief, colour how midwives interpret “normal birth”. For these midwives, “normal birth” is defined in relation to the lived “other”: the woman. The lived “other” is a “lifeworld existential” by way of which all human beings experience the world in relation to another (van Manen, 1990, p.101). Looking at the world as it is lived by the midwife encompasses the sharing of experience with women and her significant others through the birth process. In this case, the way in which both the women and the midwives perceive the experience of normal birth has an effect not only on the women, but also on the midwives themselves.

For the midwife participants, the end result of a “vaginal birth” is a normal birth. However, because the midwives work within a secondary care setting, the acceptance of intervention into their “lifeworld’s” normal birth varies widely from Sarah, who would accept a ventouse or forceps if the woman thought it was appropriate, to Bronwyn who does not accept an epidural at all. With the provision of epidural analgesia for women within a secondary care setting the midwives are aware of the effects of epidurals upon birth. There is debate about whether epidurals are a part of “normal birth” or not among the midwife participants. However, some of the midwives do identify that epidurals have the ability to influence birth outcomes (Howell, 2004; Mayberry, Clemmens & De, 2002). Initially I was surprised at each participant’s own unique perspective or notion of “normal birth”. However, having attended the Normal Birth Conference on 7 and 8 November, 2002 in Wellington I was reassured that there is a wider debate about what “normal birth” is historically, culturally, socially, and in the literature as outlined in the literature review (Downe, 1998; Kitzinger, 2000; Page, 2000). It seems that the meaning of “normal” lies in the understanding of each person. What one midwife calls “normal”, another might challenge. The levels of intervention the midwives accept within their boundaries of practice are different. The notion of “normal birth” changes with time and context; for example Bronwyn does not consider epidurals to be normal. However, Maggie talked about how the change in context had changed her midwifery

practice. Ultimately, what is accepted as part of “normal birth” within the secondary or tertiary setting depends on where midwifery is practised and the different birthing environment midwives have been exposed to.

The midwives all work in an environment where epidurals, syntocinon, ventouse, forceps and caesarean section are available and within their experience. This technology has affected their experience of keeping birth normal in some way that perhaps would be different in another setting. It also appears that the midwives are aware of the effect of intervention on childbirth that can take place within their environment.

“Seeing” is “Knowing” normal birth

“Seeing” normal birth follows on from the “notions of normal birth”, because for the participants there is a sense that midwives can only know how to keep birth normal if we observe it and experience birth as it is lived. If this experience is always seen with intervention then there is a possibility that midwives will view birth as always requiring intervention.

Maggie feels that it is important for junior midwives to observe normal labour:

I think it's really important for junior midwives to observe normal labour progress without intervention, minimal pain relief so that they get a sense of how a labour should progress in the normal setting. ...That's how I learnt ...it was really scary at first cause I thought do I really know where this woman is at? But you did and it was a real valid lesson. I think we miss out on that now because you very rarely see labour progress without intervention. We intervene far too quickly; we don't give them a chance any more (Maggie).

Maggie believes that if you do not see what normal labour can be like, then it is difficult to keep birth normal. It appears that in an environment where intervention becomes normal it is difficult to have faith in birth without intervention. This seems apparent in the hospital setting where Maggie works. Maggie learned the patience to observe birth without intervening and found it scary at first until she developed a faith and trust that

birth was progressing normally. “We intervene far too quickly...” indicates that there is a loss of patience or loss of faith that the birth will happen normally unless it is managed (Arney, 1982). The passing on of midwifery skill and knowledge to keep birth normal within the environment in which she now works appears difficult. Why is this? Is it the culture of the place where she works, with the loss of patience creating the need for intervention? Perhaps it is the acceptance of a more medicalised model of care.

“Seeing” normal birth is also important for Martha. She shares her experience with a fifth year medical student while looking after a woman:

She was a gravida 8 and on examination she had a posterior multiples os... I said to him “Just sit there with your hand on the fundus and feel the contractions and see what is happening to them”. The gleam on his face when he really felt one just building up and then just slowly going away. I said “Yes if you sit there long enough and feel when she is coming up to fully you will feel it rise up and heave down.” ...Then her toes were starting to curl a bit and I said to him “how are those contractions?” “They are getting stronger” he said, three really strong ones and then you get a little one... About half an hour later I said, “I think she might be nearly fully...” and sure enough the lady was fully dilated the head was minus two and she had intact fore-waters. With her contractions you could feel it come up and heave. The first contraction after she was fully the membranes ruptured, the second contraction the head was on the perineum.

It is just getting the students “seeing” that and going through a perfectly normal labour with no intervention. If you can show them enough of those early on before they get hooked into the idea that so much is abnormal I think they have got a far better chance to keep things more normal. I think it’s the same with all midwives. If they can see that women can do things normally...they are more accepting that these women are in pain and it does become really, really hard (Martha).

“Seeing” normal labour for Martha is an important part of keeping birth normal, especially for those student doctors and midwives that will see a lot of labours that are possibly “abnormal” in the future. Martha feels that the more they see that women survive normal labour and recognise that it is hard work, the more likely they are to have faith that birth is normal and the woman can do it. Feeling contractions and going through the pain with women, identifying that they are getting stronger, experiencing the way they feel when a woman is coming up to fully dilated, is invaluable experience of what labour is like. It appears that the lived experience of seeing and being with a woman in labour with minimal intervention helps to keep birth normal.

Seeing, recognising and coping with “transition” also seems to be an important part of observing normal labour. Smith, Priore and Stern (1973) stated that “Transition is when the cervix dilates from about 7 – 10 cm. Generally considered the most difficult phase of labour. Control can be precarious” (p.448). A woman recounting her story calls transition a “moment of madness” when she is overwhelmed with pain, and she wants to die - but the feeling of wanting to push brings her back to what is happening (Telford, 1992, p.33). The midwife participants felt that coping with women who are in transition or almost fully dilated is sometimes very difficult, and helping a woman through this time is an important part of normal birth.

In Maggie’s view, the development of epidural anaesthesia means that midwives, especially junior midwives, are no longer “seeing” women in transition as often as they did in the past, and this affects their ability to get a woman through to the second stage:

It’s amazing that transition has almost been forgotten because we don’t see it with an epidural. It affects normal birth and midwifery because when a woman gets to transition midwives jump in and say she needs an epidural, she needs an epidural. So they get these epidurals on board at 9cm and that’s it; labour stops and then they have to go down the syntocinon route and augment the labour. The woman may have had an OP baby just prior to the epidural going in and she ends up with an instrumental delivery because the baby doesn’t rotate in the second stage; that is what I see happening a lot.

I know what transition is like with and without pain relief because I have been exposed to it so many times. Women change; their epidural doesn't work, they get all agitated and they vomit. There are all those signs that they are coming up to fully dilated. It is getting harder because of epidurals to be able to stand there and let a woman scream and shout as she is going through that really difficult time because you're not exposed to it so much anymore... I think if that is changing for me, it is going to change for a lot of new midwives that come through (Maggie).

Maggie points out that the easy availability of epidurals have affected junior midwives' experience of normal labour, and especially of the way that women cope with transition. It does seem that the women become louder, more irritable and bad tempered; they vomit and are agitated (Telford, 1992). Maggie regrets that the junior midwives' answer seems to be to have an epidural because they are afraid that the woman is not coping. Or is it the midwife who is not coping? Maggie admits that it is hard to let a woman stand there and scream and shout. It is frowned on if a woman is making too much noise (Hunter, 2003). Maggie believes that it is part of a midwife's role to get a woman through the pain of that difficult phase of transition to second stage.

Maggie observes that epidurals have increased the instrumental delivery rates. A Cochrane review by Howell (2004) found that epidural analgesia is associated with a prolonged first and second stage of labour, as well as a predisposition to fetal malposition and double the use of oxytocin (syntocinon). The review also found that there is an increased risk of instrumental vaginal deliveries with epidurals. Maggie believes that to keep birth normal, midwives need to be exposed to labour without an epidural. They need to learn to help a woman cope through the difficult transition phase. It seems that with the advent of technology there is a view that women do not need to be stressed or lose control, because it can be managed with an epidural. There appears to be a change in social consciousness to encompass the belief that all pain is to be avoided, or at least kept under control. Therefore it is even more difficult to cope with women's pain, without using the available technology to "fix it". This technology, however, can have adverse consequences, and can lead to a cascade of other interventions.

Martha shares Maggie's view on recognising transition and helping midwives to assist women through this difficult time:

...I find a lot of the junior midwives and the women don't cope unless you are there to back them and they will be getting epidurals. Yeah it's hard work going through transition but the more they can see that the woman comes through the other side really great without mental or physical harm, it gives them more ammunition for the next woman to say "Yes you can do it" and it is just a very short time of the labour (Martha).

Martha identifies that there is a need to support not only women through the transition phase of labour but also junior midwives. It appears that experience of the midwife helps to get a woman through this difficult time. Midwives "seeing" women go through transition without epidurals seems to be an important part of learning to keep birth normal. It gives midwives the knowledge base, skill and strength to work with the woman through the difficult phase of labour without feeling they need to intervene (Hartley, 1999). Time during transition as it is lived is perceived by Martha as only a short time of the labour, but time for the woman or the junior midwife might be perceived as being too long to cope with (van Manen, 1990). It seems that having the knowledge and understanding of women in transition gives the experienced midwife a more realistic perspective on time.

Kay, like Maggie and Martha, talks about the experience of knowing and observing, when seeing transition in a labour that is progressing normally:

A midwife came out to me the other day and said they thought their woman needed ¹syntocinon. She was a multip and she had an ARM two hours previous at 6cm. I was quite surprised that she would need syntocinon. ...Anyway I went

¹ Syntocinon is an infusion of oxytocin to augment labour and is usually administered according to protocols of each delivery suite. Lower doses of syntocinon are used for women with previous pregnancies and used with caution in those women with a previous caesarean section for fear of uterine rupture.

into the room and this woman was heaving and carrying on like she was just about in second stage. The woman was in transition and they can often have a bit of a lull where the contractions can go off and she'd had that lull and she was just starting off again. For the midwife that was looking after her it was probably a little bit of inexperience in that she wasn't able to assess what was happening with that woman from watching how she was behaving. Using syntocinon can sometimes seem almost normal. I think that was the first thing that came into her mind, is what she could do to help this woman's contractions or help this labour along because it seemed to have stalled but in fact it was just normally progressing (Kay).

Kay observes that experience and thoughtful observation help to keep birth normal. In her experience, women can have a lull where the contractions can go off. Flint (1986) called it the “rest and be thankful” phase of labour, where the woman can rest for an hour or more and then the contractions will build up again ready for when she is getting ready to push (p.66). It reminds me of the saying, “The calm before the storm”, and it does seem to be part of what can happen in normal birth. Kay also feels that the midwife lacked experience to identify what was happening with this woman. It seems to be about having patience, watching and waiting. Is there pressure on the midwives to keep within certain protocols of the hospital in terms of progress of labour? Was this more junior midwife trying to ensure the labour was conforming to expected management and protocols? The senior midwife with experience is more able to assess the whole situation.

Kay believes that in working in a secondary care setting, the use of syntocinon can sometimes seem “normal” because it is a tool that they so often use to help with the contractions. However, she also recognises that it should be used appropriately. It appears that Kay, the senior midwife who has experience and knowledge, gives advice or intervenes at times to keep birth normal. Like Maggie, Kay believes that technology has developed syntocinon to fix contractions, in the same way that epidurals can fix pain, thus altering “normal” and the way it is perceived in the midwives' consciousness.

To summarise the sub-theme of “Seeing normal birth”: the midwives in this study recognise that to develop a “notion” of what normal birth is it is important to observe normal labour as you grow in your experience as a midwife. van Manen (1990), when referring to the lived body, talked about being a father and observes: “that I look with fatherly eyes ...at the feverish color of my child in his sick bed...and this ‘seeing’ prompts me to do something to act the way a father should” (p.105). “Seeing” transition and birth with little or no intervention enables midwives to help women cope with what is “normal”, and also learn to cope themselves, so that they “act the way a [midwife] should”. The midwives remember their experiences of “seeing” normal birth and this seems to be part of their development of “being a midwife”. The midwives have identified that the more junior midwives need support, reassurance and encouragement from experienced senior midwives in order to nurture the ability to keep birth normal.

Believing in normal birth

The midwives in this study shared their experiences that seemed to be about being confident in their practice, and sharing that confidence. However, after further analysis, this confidence in practice appeared to come from a deeper place. It is a confidence that comes from a fundamental belief in normal birth. This belief has two consequences. The first is that they can push the boundaries of practice and perhaps not go “completely by the book”, affording them more flexibility. The second is that the midwives appear to share their beliefs in normal birth not only with women but also with colleagues, junior midwives, students, and doctors, in order to keep birth normal. Gabrielle observes that experience as a midwife gives you the ability to go along with what is happening:

If something doesn't go 'completely by the book', you can go along with what's happening because...you have a pretty good idea a certain path will follow and the woman will have a normal delivery. Experience helps you a lot. I've looked after hundreds of women in labour. I know when it's normal and abnormal because you've seen so many labours and births (Gabrielle).

Gabrielle recognises the value of experience as it is lived. She has a knowledge or knowing about normal birth because she has seen so many labours and births and has experienced it in her everyday practice of “being-in-the-world” as a midwife. Dreyfus (1999) referred to Heidegger and “Dasein’s familiarity”, or being familiar, because of our background experiences: “It is being ready in particular circumstances to respond appropriately to whatever might normally come along.” (p.103). It appears that the midwife is prepared to push the boundaries or enlarge her scope of practice within a secondary unit when she says she may not go “completely by the book” because she is confident that the woman will have a normal birth. What does “completely by the book” mean? It means strictly, according to rule, stringently, lawfully, officially, formally (Cambridge Dictionaries Online, 2004). Perhaps it is about not following protocols or guidelines strictly because you believe it will work out through experience and knowledge. She brings her past with her to understand the present and allow the future to unfold (van Manen, 1990). Is this about how the midwife perceives what normal and abnormal is? Or is it that she has a belief in normal birth because she has seen it and she is experienced in the knowing of “normal birth”? I sense a patience with the process, a “go[ing] along with what’s happening”. Is this about not presuming too early that it is abnormal? Perhaps there is a belief that the woman will have a normal delivery because it is already there within her deeper understanding born of experience. Does that give the midwife the ability to be flexible within her practice?

It seems that for Gabrielle, the belief in normal birth is developed from seeing normal birth and experiencing normal birth, which then enables her to go along with what is happening and then not be practising within too rigid a framework. Bronwyn also shares the same notion within her experience of remaining positive and confident to keep birth normal, even if she is challenged:

A Japanese woman who had a previous caesarean section at another hospital was in good labour. I was looking after her as well as being in charge and she wanted a normal delivery. So I said, “Look there is no reason why you can’t have a normal delivery. The previous one was for foetal distress at four centimetres and you have been doing really well.” So I did a vaginal examination and she was one centimetre dilated and I thought, “Oh this could

be a problem.” Anyway, I just played it down and told her that she was doing really well and suggested that she have a shower. I kept her in the shower for some time and then suggested she have a bath. She was really happy to have a bath. The interesting thing was every time she got a contraction she climbed out of the bath and when she didn’t have a contraction she got back in the bath and she really liked it. I couldn’t quite work out why she would climb out with a contraction and we had water everywhere, everywhere. I just kept encouraging her and she had enough of the bath so we went back to the room, she had progressed to 4-5 cms.

She was doing really well but I couldn’t leave her in the room because she needed confidence and security. I think that in five minutes you can build up a rapport ...I think she had this confidence in me that when I wasn’t in the room she felt lost and she didn’t feel secure or safe I suppose. If I left the room she rang the bell and then you would go in the room and she would be all right. So you just knew that you had to stay with her if you were going to get her through. I thought I couldn’t just stay with her and answer the phones and things so I got a student midwife and I said, “All I want you to do is hold her hand and talk to her”. I was in the room most of the time but the student midwife was there when I had to go out. Then she got to fully dilated so I thought I better let the student do the delivery. So she was pushing and she had a nice normal delivery and she was so excited she said, “I did it, I did it, I did it. I couldn’t have done it without you,” and she was just so over the moon that she had actually done it.

The woman wanted a normal delivery so I think deep down she would do all she could but I think you had to have somebody that was going to give her the confidence to do it. It’s a confidence thing, she only needed to be told that she could do it. A few days later I got this lovely photo and this big thank-you. Now she knew that the student was doing the delivery but that was totally irrelevant she just couldn’t thank me enough and it was a really good buzz because she was just so thrilled with her experience. I probably didn’t do all the things I should have done for a previous caesarean. I can’t remember if I put a leur in,

but yeah there weren't any doctors involved and it turned out really well
(Bronwyn).

Bronwyn talked positively to this woman with a previous caesarean section. When she examined the woman and found her to be only one centimetre dilated it indicated that she was not really in established labour, and identified a possible problem. However, the midwife “played it down” - in other words she did not make this an issue and say, “Oh but you are only one centimetre!” She remained positive. It would have been so easy to be negative about the woman’s state, knowing of her previous caesarean section, and to have been governed only by the perceived “risk” involved in caring for her. “Being positive” and “giving confidence” is part of Bronwyn’s skill in keeping birth normal. She creates an environment for the woman to feel safe and secure, to allow normal birth to take place (Parratt & Fahy, 2004). van Manen (1990) referred to space, as it is “felt” (p.102). It seems easy to talk about the size of a room or “mathematical space” or measured distance, but lived space is about space that is felt. Different spaces have different significance. It is a reference for the world we live in, in terms of our profession, interests and background. van Manen gives the example of the experience of home for a child as it may be felt. It might be “supportive or neglectful, open or smothering, liberating or oppressive” (p.106). The midwife talks about how she had created a safe space for the woman to give birth.

Bronwyn does not raise the issue of pain relief. She offers the woman a shower, and the woman goes and has one. She offers the woman a bath, and the woman accepts it. It is interesting to note that the woman gets out of the bath during a contraction, and there is water everywhere, but again the midwife goes along with it, and with whatever helps the woman cope with the pain. The relevant effectiveness of the use of non-pharmacological and pharmacological pain relief in labour and how it affects normal birth has been well documented (Bastion, 2003; Bennett & Brown, 1992; Enkin, et al., 2000; Howell, 2004; Leap, 1996 & 2000; Vague, 2003). Bronwyn seems to show that by the woman “doing” these things, like movement and enjoying water, she is encouraging normal birth to occur. Bronwyn also recognises the woman’s need for her to be present. The woman’s actions were telling the midwife that she needed to support her and “stay with her” and “get her through”. So she finds a student to help provide

support when she is not able to be there. Then, when the student conducts the birth of the baby, the woman and the midwife still perceive that they did it together. “Being supported” is a key factor in how women feel about the outcome of their labour (Enkin et. al, 2000; Vague, 2001; Waldenstrom, 1996).

Bronwyn acknowledges that she did not do all the things that she was “supposed” to. Was this to avoid planting a seed of negativity? Is it about stretching the boundaries of clinical practice as you gain more knowledge and experience? Scarlet (2002) identified that you can be self-confident but not competent, which can lead to errors and cause harm. Competence is developed by “knowledge, skill, practice and experience” (p10). Bronwyn not only demonstrates self-confidence, but also a competence in what she does. She has developed the “...knowledge, skill, practice and experience” to recognise what is happening clinically, and to ensure a normal outcome. Bronwyn believes in her own skill to maintain safe practice when stretching the boundaries, and in her ability to act quickly when necessary. She would surely have intervened, if it had become necessary, to put a luer in, but the situation did not arise.

The important thing seems to be that she has empowered the woman, who recognised the value of the midwife’s support, and her belief that her labour would progress normally. This confidence was possibly transferred to the student as well. There was no continuity of maternity care for this woman, who was in the hands of the midwife who happened to be working in the unit on that particular day. Yet the woman and the midwife built up a very strong rapport and a trust. It seems that Bronwyn’s belief in normal birth meant that she did all that she could to help the woman believe in herself, and believe that she could achieve a normal birth.

Martha also starts by being positive about a normal birth, even though she is challenged because the woman has had a previous caesarean section, a forceps, and a ventouse, and she thought she would never have a normal delivery. Martha says to the woman:

“We’ll do it normally this time,” and that is also what the woman wanted. So the junior midwife and I worked with her. She was in the shower and we encouraged movements until she had an anterior cervical rim. I then encouraged her to get

into the position with her head down bottom up, shoulders flat on the bed, knees apart and just rocking, and in about 10-15 minutes the head was on the perineum. She had a nice normal delivery. OK, when she was pushing she didn't like it. She said, "I want a section or a ventouse, an epidural at the least," but within seconds of having the baby she was over the moon. It was something she didn't think that she would ever do was pushing out her baby on her own. She was chuffed and the junior midwife was quite impressed at the progress with her turned upside down. She didn't expect that to happen, but it tends to work more frequently than not. It had taken tremendous pressure of her tail... She went home four hours later, proud as punch. You could see her walking, strutting down the corridor with her baby and yeah she'd done it (Martha).

Martha worked with the woman and the junior midwife to help them achieve a normal birth without a caesarean, a forceps or a ventouse. I loved it when she told me about the woman strutting down the corridor as proud as punch with her baby. Martha appears to keep birth normal by demonstrating a confidence in her practice, saying to the woman it would be normal this time and being positive despite three previous abnormal births. She works with the woman in the shower and encourages mobilising and frequent changing of position. She shows the junior midwife the "tricks of the trade" that help achieve a normal birth. This process of working with women and their pain in labour has been suggested as an important key to keeping birth normal (Leap, 2000; Vague, 2003).

Martha never thought that the woman could not have a normal birth without intervention. She was not negative, and showed almost a determination to prove to the woman that she could do it, because Martha believed that she could do it. Like Martha, Maggie also demonstrates a belief in normal birth, as she shares her experience of a woman who was a model. She ran marathons, and was very worried about the effect a normal birth would have on her body:

She booked under an obstetrician and he told her that they'd have a go and if she did not progress then she would get her caesarean that she wanted, to

prevent her pelvic floor muscles from deteriorating. She came into the delivery unit late at night and we talked about pain relief options and I found out why she thought caesarean section was a better idea, and what effect caesarean section could have on her and her profession. I knew that she needed to get back to work and be body fit fairly soon afterwards. It took a little while for her to realise, and I explained to them normal labour and the normal process and how it can take a long time.

She went into labour during the hour and spontaneously ruptured her membranes so I called the obstetrician in and she was about 3cm dilated. The obstetrician was very keen for her to have an epidural knowing that she wanted a caesarean. However, after our discussion she said, "Oh no. I'll continue and see how we go. I don't want an epidural just yet. I'll see. I'll be fine," and so she continued. Unfortunately she did end up with an epidural in the end at about 8cm which I thought was good. She had an epidural mainly for her partner. He was getting very upset seeing her in pain and he couldn't handle that. She was probably going through transition where it was getting really tough for her and he was getting very demanding. She then had a nice normal delivery.

Changing her expectation was the bonus for me and she trusted me quite quickly even though I had never met her before. I gave her all the information that I think she needed to sort of realign her thoughts. I felt she was being given an injustice by the information she was feeding back to me. She was telling me that apparently a caesarean section was better than a vaginal delivery and that concerned me.

Absolutely nothing happened to her pelvic floor, and in fact she got pregnant nine months after and I have spoken to her because I followed her up. I thought, "Oh God, if her pelvic floor does fall apart she is going to be really peeved at me", even though I knew it wouldn't because I discussed pelvic floor exercises with her and she ended up with an intact perineum. She resumed a normal sex life and I did discuss that with her about six weeks later. She came in to give me

a present. She said, “Oh it’s fine, great.” It was a real positive for me. We very rarely get a chance to follow up, especially in this hospital as midwives, unless something goes wrong and then you get to hear about it (Maggie).

Maggie spent time discussing birth options and normal birth with the woman, because she felt that the woman had not made an informed decision. Even though the woman had a private obstetrician as her LMC, Maggie still managed to convince the woman to try for a normal birth. Johanson, Newburn & Macfarlane (2002) identified that “obstetrician involvement and medical interventions have become routine in normal childbirth without evidence of effectiveness” (p.892). They have also found that increased intervention is associated with “...private practice, medical legal pressure, and not involving women fully in the decision making”(p. 892). They suggested that higher rates of normal births are linked to beliefs about birth. The attitude and behaviour of those that care for women in labour can have a powerful influence on what happens during the birth process, and on satisfaction with the outcomes (Hodnett, 2002). Maggie could have thought, “Oh well, it is out of my control. I’m not the woman’s LMC. The decisions and plans have already been made”. What made the difference, to make Maggie want to try and discuss the plan that the woman had made with her LMC? It was Maggie’s belief that the woman actually could have a normal birth that encouraged her to try to change the woman’s expectations.

Normal labour can take time, and when some women want childbirth to fit into their busy lives, time for childbirth becomes a restriction for them. For some women, having a caesarean section may seem like an option that gives them more control over timing. What they do not realise, however, is that having taken the time to have a normal birth, a woman will then be up and about the day she actually gives birth, whereas it often takes many days to recover from a caesarean section.

It is very evident that the “physical body” has an importance for this woman. Maggie is conscious of the fact that if the woman did later have problems with her pelvic floor, then it may have created resentment towards the midwife over the decision to pursue a normal birth. A third of women may have some urinary incontinence three months after childbirth (Glazener et al., 2001; Wilson, Herbison & Herbison, 1996). However,

although studies have found that caesarean section can give women some protection from urinary incontinence, it is also known there is negligible difference with increasing age and multiparity (MacLennan, Taylor, Wilson, & Wilson, 2000). Young (2003) observed that midwives are looking at normal childbirth with suspicious medical eyes, and are not advocating for normality. Conversely, Maggie demonstrates that she indeed advocates for the normal. As Maggie relates to this woman, she cannot escape her belief in normal birth, and has passed it on to the woman.

Developing a “little rule of thumb”

“My little rule of thumb” is an expression that Kay uses to describe something she does as part of her clinical practice. She acquired her “little rule of thumb” by learning from another midwife. The midwifery profession has passed on knowledge orally throughout history, from midwife to midwife and woman to woman (Arney, 1982). The midwives in this study revealed how they learn their midwifery by sharing and listening to other midwives, picking up skills especially when endeavouring to keep birth normal.

Kay shares the knowledge that she has gained from other midwives:

When I was a new graduate midwife, one of the experienced midwives said to me, “Never rupture a multip’s membranes if she is less than 6cm”. Because often you get these ones that are 4-5cm that aren’t really in labour and then you end up with that cascade of events or intervention, that’s my little rule of thumb... I learnt my midwifery from other midwives and it does certainly make a difference, the more confident the midwife, the more she has been exposed to and been in situations the more you learn. You are always learning and picking up skills from other midwives. Midwives have taught me everything (Kay).

The passing on of knowledge and experience from midwife to midwife has resulted in Kay having a “little rule of thumb”, something that she feels she must consider in her midwifery practice to keep birth normal. She has an awareness of avoiding the unnecessary “cascade of intervention” that she has acquired from other midwives (Mead & Kornbrot, 2004; Tracy & Tracy, 2003). Kay also recognises the importance of “picking up skills” from other midwives to assist her to keep birth normal. Sharing

knowledge and teaching each other seems to be an important part of keeping birth normal.

The following midwives all emphasised the importance of discussion and sharing their knowledge from and with other midwives, in a supportive non-critical way that encourages midwives to grow in confidence with their own practice and decision making:

I think what helped me to develop in midwifery is recognising and having more confidence in my own abilities - not only more confidence as a person, but confidence in my clinical skills as well. It does come with experience and with discussing cases with more senior midwives, not just through a debriefing session but sitting around in the tearoom discussing cases openly. Just saying, "Look, did we manage that case well, or do you think we could have done it differently?" - listening to other midwives and independent midwives who have got so much wealth of experience and knowledge and taking it all on board really (Sally).

I actually like to be there to support new people. Our tea-room is a great discussion room for nearly every labour that's ever happened at the hospital. We go through cases and discuss about the women that they have cared for. I talk to new people in a non-confrontational way, where they can have their ideas and views aired and you can have yours. This way they will come and ask. They will listen and hopefully feel supported by me. I also let them do it how they want to do it and don't push my ideas onto them because there are so many ways to do it (Gabrielle).

It is important to support junior midwives in their practice to enable a woman to have a normal outcome by getting them to discuss what is happening and why they are going to do things. So they are actually thinking about what they are doing, not just blatantly following written protocols or guidelines. Discussing cases with you and going over them, not so that they can be criticised for what they have done, but so they can perhaps have different ideas put forward.

Always be positive with them and always give encouragement. If they are doing something bloody stupid let them know. It's an individualistic practice really; so long as they comprehend why they are doing something and the consequences of it (Martha).

Sally shares her experience of developing confidence and experience in her clinical practice from discussion with other midwives, and reflecting upon her experiences when caring for women. Senior colleagues gave her the confidence to modify her practice in the future to assist in a normal outcome. For Gabrielle, teaching junior midwives and imparting her knowledge of midwifery to achieve a normal birth is about being able to reflect on practice, openly discussing cases in an environment where the midwives feel they are supported and can share opinions. It is also about being approachable, and the midwives being able to try it their way. Martha also feels that midwives should be able to explain their actions within a non-threatening environment, to learn to think about why they may be intervening or not, so they can learn from their experiences and gain confidence in their own practice. Creating a thoughtful practitioner appears to be an important part of midwifery practice and birth outcomes. Martha is aware that protocols and guidelines are there as a tool, but indicates that there is a need to be flexible, as well as accountable. This comes from experience and reflective practice.

Kay describes the role of the charge midwife as she assists less experienced midwives, and shares her expectations of clinical practice:

Some of the less experienced midwives have to be given enough "space" to develop their own skill, and a way of working without feeling uptight or worried about what is expected of them. I allow the midwives who are looking after the women to think about what they are doing to organise their care. I'm not going to keep going in there and saying, "Have you done this?" or "Have you done that?" but I might pop in and say, "Are things all right?" They might say, "Oh I was just going to come and tell you this or I was just going to do this, or what do you think about this?" and I think that is how it should be (Kay).

Kay feels it is important to give midwives “space” to develop and grow in confidence without worrying about expectations. “Lived space” is about space that is felt (van Manen, 1990, p.102). Although she is the charge midwife, she sees her role not as one in a hierarchical system where she is the ruler, but as one of support and advisor. She wants the midwives to develop confidence as practitioners and develop autonomy of decision making. However she does show that they still require support in the process of learning midwifery knowledge and skills to keep birth normal, because she asks them if things are all right and is happy to share her thoughts with them.

Historically, however, the position of charge midwife is a hierarchical one. Griffiths (2004) described the delivery suite co-ordinator as being “elitist and nurse-like”, with the philosophy that a “midwife is a midwife”, and there is a lack of professional responsibility to nurture less experienced midwives into the co-ordinator’s role (p.16). This appears to question the need for leaders with experience or the need for advisors and that all midwives practise autonomously at the same level. If there is no clinical co-ordinator or charge midwife who do the midwives consult with, the doctor? Is this about sharing from midwife to midwife and not midwife to doctor? Kirkham and Stapleton (2000) suggested that the hierarchy created within large hospitals “reinforces the values of obstetrics not midwifery” (p.466). However, they point out that a loss of experienced senior midwifery staff can result in lack of support for midwives. The more junior midwives may require midwifery advice to keep birth normal, but if they refer to the doctor all the time then all they will receive is medical advice. The midwives in this study make it clear that they needed to learn from other midwives, in order to gain confidence and experience in keeping birth normal within a secondary care setting, and that care within that setting needs to be midwifery-led and not doctor-led. They believe that having a clinical charge midwife or co-ordinator has its place in keeping birth normal, because it can be a supportive midwifery advisory role. Through a consultative process, experienced midwives share midwifery practice ideas with less experienced midwives, and this sharing helps these midwives learn how to keep birth normal within a secondary care setting.

Summary

“Being a midwife” was expressed by Maggie as an integral part of the “notion of normal birth”. Part of “being a midwife” is to assist a woman towards a normal birth outcome. The understanding of “being a midwife” keeping birth normal can change, depending on the context and over time. The midwives have conflicting views about epidural analgesia available within a secondary care setting and its effect upon the notion of normal birth. “Being a midwife” is different when one is looking after a woman with an epidural. The notion of “normal” is also different for each midwife. The midwives in this study concluded that part of “being a midwife ‘is’ keeping birth normal”.

“Seeing ‘is’ knowing” normal birth is also a part of keeping birth normal. The midwives’ previous experiences of normal birth mean that they can help to keep birth normal because they have a knowing about what it is and how it unfolds. They suggest that if midwives do not see birth without any intervention, then it is harder for them to keep birth normal.

“Believing in normal” comes from seeing normal birth, having experience, and gaining knowledge. This develops confidence in the process, and the ability to give confidence to the woman and junior midwives. There is a perseverance, patience and determination to always keep trying to achieve a normal birth outcome for women. The midwives are also very conscious of the woman’s birth experience throughout the process and they recognise the importance of making birth a positive experience.

Developing a “little rule of thumb” highlights the importance of midwives’ long oral history of learning about normal birth from one another. The midwives indicate that the different components of keeping birth normal are an integral part of “being a midwife”. They are essential to their role, their “Dasein” or everyday being.

CHAPTER FIVE

Stepping back or stepping in

Introduction

The previous chapter, “Being a Midwife ‘is’ keeping birth normal”, explores the notion of what “normal birth” is for the midwives in this study, and articulates what that requires of them in order to keep birth normal. The title of this chapter, “Stepping Back or Stepping In”, comes from a phrase used by one of the participants in relation to the decisions she makes about whether to intervene or not. This was supported by the experiences of the other participants.

Although it appears that when they work within a secondary care setting, midwives are influenced by obstetric policies and guidelines to intervene unnecessarily (Guilliland & Pairman, 1994; Stafford, 2001; Walsh, 2002). The participants in this study show that in fact they do have an influence on normal birth outcomes, by making their own judgments about whether an intervention is appropriate or not.

The participants shared their experiences of making the decision about whether to step back or step in when working with students, junior midwives and women, and the way that this decision-making may influence birth to be normal. Women themselves, and the choices they make during childbirth, also influence the midwives, and can affect the birth process and outcomes.

Stepping back or stepping in

The midwife participants pointed out that within a secondary or tertiary facility it is presumed that they will teach and share their midwifery knowledge, with student midwives, new graduates, nursing students, medical students and doctors. As a result, the midwives see it as part of their role to share and pass on their knowledge in order to keep birth normal. Bronwyn expresses her thoughts on learning midwifery:

I think it is like this in midwifery... You can learn the textbook but it tells you very little, as far as I'm concerned. The textbooks tell you the structure and that's it. The rest is a really learnt art and that's where I think junior midwives need support to develop that (Bronwyn).

Bronwyn identifies the limitations of learning from midwifery textbooks. She believes that it is important to learn by experiencing the everyday practice of midwifery by passing on the “art” of midwifery from midwife to midwife. There is a “knowing” that is created through everyday clinical practice. It is important for experienced midwives to pass on the knowledge of normal birth that has been gained through experiencing women in labour. They share how they learnt what “being a midwife” means from other midwives before them, and support junior midwives in the same way.

Sally shares her experience of being a charge midwife and supporting other midwives:

I think it is definitely important to support other midwives, especially junior midwives, in order to enable them to have normal outcomes with women. ...If I do go into a birth to support a more junior midwife I do try and keep quiet and allow them to do most of the conducting of the birth. If everything is normal then I “step back” a bit and allow them as much time to do this birth themselves, not to “jump in” too quickly and start shouting out for this woman to push better. I don't need to “jump in” there heavy-handed, unless I feel there really is a need to “step in” and take charge, if I think there is a problem. I feel that not only with the junior staff but other staff members of the team (Sally).

Sally supports the midwives by stepping back and allowing the midwives to conduct the delivery with the women themselves and tries not to jump in too quickly unless she thinks that she needs to step in and take charge. This relating to “other” less experienced midwives is about relating to “the lived other”. “The lived other” is one of the lifeworld existentials that van Manen (1990) uses as a guide to reflection as outlined in Chapter Three. “Lived other” is “the lived relation we maintain with others in the interpersonal space that we share with them” (p.104). Heidegger stated that being with others sometimes means taking care of others in two ways. One way is to leap in for the other,

taking over the care for him or her. However, a person leaping in can sometimes displace the other, and may take over what he or she should have taken care of for him or herself (King, 2001). The second way is to leap ahead, not to take the care away, but to give it back to the other. Different situations are complex, and leaping in may be required sometimes, while leaping ahead may be appropriate in other situations (Smythe, 2002). When the midwife is working with students and helping them to learn, it may be appropriate at times to leap in and show the student what to do. At other times it might be necessary to leap ahead and empower her to care for the woman, and keep birth normal in her own way. Judging when to step back or step in is part of giving confidence to “the other”. It means being confident in practice and helping to develop a belief in normal birth.

Bronwyn shares her story about a junior midwife and a student:

A reasonably junior midwife had a student with her and I knew the woman wasn't pushing very effectively. Her arms were around the mother's neck and the push was going into her head and up around the arms and there was nothing to see on the perineum. Anyway I thought that they had only started pushing and I wouldn't say anything. I would let them continue and I went out of the room. I waited 20 minutes and I went back in and the same situation, just wasn't effective pushing, no sign of the baby so I thought right we have only been pushing 30 minutes. I was trying to work out how much time I could give them and said, "Keep going," and then I thought after a while if I don't "step in" now we are going to run out of time. Then I said, "OK we need to change things," so the first thing I said was "Take your hands from around your mother's neck and put them around your legs". I said to her mum, "Now you support her neck and shoulders because if she is swinging on your neck then she can't push into her bottom". She was lifting her bottom right off the bed and so I said, "Right, with the next contraction I want you to push it right down to the back wall". Well she was so effective, and the baby wasn't that huge, that the midwife didn't have time to put her gloves on. This baby just shot out. It was like you couldn't see the baby and she just gave this effective push or she might have had two pushes before we saw the baby and they didn't get their gloves on.

That was just like effectively managing second stage or picking which babies will fall out and which babies will actually need to be pushed out or directed. So I think that's experience and teaching people (Bronwyn).

Bronwyn has, through her own experience, determined that the woman is not pushing in a way that will enable her to give birth to the baby. However Bronwyn does not want to undermine the more junior midwives in their efforts to assist and support the woman to give birth. She tries not to intervene so that the junior midwives and the woman can do it their own way. She then realises that she needs to intervene if the woman is to give birth because there appears to be a time limit on how long the woman can push for without seeing any descent of the baby.

The context of the secondary care setting has, through policies, procedures and protocols, certain expectations that at a particular time interventions will occur. Has the expectation that labour will be shorter meant that the doctors will only leave a woman alone for so long before deciding that a woman needs some medical intervention? Bronwyn was trying to work out how much time she could give them before the time ran out. It seems that the expectations within a secondary care setting means that sometimes there is not enough patience to watch and wait for birth to unfold. There is a feeling of running out of time, because there is the expectation of an intervention.

Some may consider that instructing a woman to push is an intervention in itself. Anderson (2002) suggested that getting a woman to push in this way is indeed a high level of intervention. She even says that midwives themselves are a significant intervention, and that giving birth in hospital “distorts the physiological process of giving birth” (p.207). Bronwyn talks about effective pushing. There seems to be a way that a woman pushes that will help her deliver her baby, and if she does not push in this way, then she is expending her energy but not achieving her goal. The way midwives assist women to push seems to have an effect on whether they will deliver normally or not - that is, if they require assistance. Bronwyn eventually decided to direct the woman to change her position, and showed the junior midwives the difference it made by directing the woman to push in an effective way.

This is about keeping birth normal by the sharing of experience: a “knowing” about women who need guidance and those who do not, and a sharing of that knowing. There is also the issue of time, and the constraints of achieving a normal birth before the woman may have received more interventions, and not had a normal birth. Why did the midwife not tell them straight away that the woman was not pushing effectively? Was it to prove a point? Was it to make the learning more significant? Or was it truly to give the woman and the junior midwives a chance to do it by themselves first? Whatever the motive, I am sure that those midwives will never forget the experience.

The midwife talks about needing to “step in”, or as Heidegger puts it, to “leap in” (King, 2001). The midwife did not initially leap in, however. Did she “leap ahead” and show them how to do it, without discounting the efforts they had made? Or was it not possible to “leap ahead”? Did the midwife have no choice but to “leap in” to keep birth normal? Perhaps the environmental constraints of “time” meant that she had to or perhaps she thought this particular baby might not cope with a prolonged second stage.

Something minor to prevent the major things

There is recognition by the midwife participants that there are many situations where women have interventions within a secondary or tertiary hospital setting during birth. They regard varying levels of intervention as part of “normal birth” before they consider that birth becomes “abnormal”. Trying to achieve the balance or the right timing of an intervention seems to be important for the midwife participants in their efforts to keep birth normal and prevent the major obstetric interventions like an instrumental delivery or a caesarean section.

Bronwyn talks about patience, judging when an intervention is required, and balancing technology:

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 things.”

I think it is balancing technology and women who you think “Well it doesn’t matter if I ARM [artificially rupture membranes] her or not she will progress; versus I need to ARM her otherwise she is going to get stuck and will not progress”. “This woman doesn’t need fluids,” versus picking that this woman needs 500mls and it will just give her something and get her going”. It’s a real judgement and I don’t think we are as patient as we used to be and that’s a problem. It is a patience game and I suppose it’s the skill of knowing how much time. Like prostins came in and they speeded up the ripening of the cervix. Then syntocinon came more in use and we sped up the labour. So all those things have sort of happened and it’s like trying to get the balance. Before prostins we were quite happy to use syntocinon for eight hours effacing the cervix. Now nobody will sit on syntocinon for 3 hours effacing the cervix and they start calling it prolonged labour and I think we’ve lost that patience, that skill, we just expect these labours to go quickly. When I trained we said 24 hours for a primip. Now we say 12, and what has changed in that time? (Bronwyn)

For Bronwyn, assisting a woman to have a normal birth is about experience, picking who requires intervention and who does not as well as knowing the appropriate timing of intervention. She refers to “patience”, “judgement” and “balancing” as key issues when talking about achieving normal birth. The midwife needs to be patient. She needs to judge when and if to intervene, balancing technology and intervention with patience and non-intervention. She talks about changes in expectations regarding the use of technology like prostaglandins and syntocinon.

Through the midwife’s experience she has developed the skill of “knowing”. How does she know when to intervene and when not to, when to use technology and when not to? Is it what she has learned through her everyday experience of being a midwife, by being patient, balancing intervention and non-intervention, and making good judgments? Is it by observing, seeing many women in labour, and recognising the signs that she has experienced many times before, that she has developed the intuitive sense of “knowing”? She recognises that sometimes it may be necessary to step in and do something minor to prevent the major interventions. “Minor” might mean an ARM, or just giving the woman some fluids.

Bronwyn identifies changes in “time” when it comes to labour. “We” have changed the speed of labour. Once, a slow pace over 24 hours was “normal”. Now 12 hours is “normal”, which calls for intervention to keep it up to speed. It appears that the parameters of “normal” are socially constructed, especially when it comes to the timing of labour. Crotty (1998) stated that “social being determines consciousness” (p.61). In other words, our point of view, or the way we think, is shaped by socialisation with others. Bronwyn recognises that with the invention of drug technology like prostaglandins and syntocinon, society has changed its view to assimilate the belief that there is a need for speed in labour. Because labour is expected to be shorter, then there is not the same value given to patience and waiting to let the birth be “normal”. Time, in relation to how it is lived regarding labour, is time that is now sped up, or less than it used to be, reflecting the historical changes in people’s expectations (van Manen, 1990).

Like Bronwyn, Maggie is also concerned about technological advances and the way they are viewed in society. Maggie believes that ensuring a woman has a normal birth means the prevention of caesarean section:

I think if they don't labour normally and naturally the outcome tends to be poor in the sense that they could end up with an instrumental delivery or ultimately a caesarean. So to me it's prevention of caesarean. I don't think a caesarean section is a good option for childbirth even though a lot of people nowadays are choosing that. To me it's still not the ideal method of delivering your child especially if you are going to have more than one. It's getting harder because caesarean section is becoming more the norm. It's not quite the norm yet, but to have a caesarean section is not as problematic as it used to be. It still has its side effects and its problems for mum and baby (Maggie).

It seems important to Maggie that a woman labours normally or naturally. She suggests that if a woman’s labour is interfered with too much it can lead to a woman having an instrumental delivery or a caesarean section. Maggie always does what she can to prevent caesarean section. She does, however, recognise that it is getting harder to prevent caesarean sections because more women are choosing them, and they are no

longer seen as problematic. Does this indicate a “normalisation” of caesarean section in our society? Caesarean section was once seen as a life-saving procedure; a last resort. The use of this technology has become more common and has become an alternative choice for some women. Papps and Olsen (1997) suggested that some people believe that normal birth is traumatic for babies, and caesarean section prevents this trauma. The mother and fetus are seen as separate and conflicting. There has been a change of perspective from the outcome for the mother and delivery, to the outcome for the fetus. They also point out that there are views that go even further, to insinuate that through socialisation and acceptance of caesarean section it may be that in the future caesarean section is the “norm” and normal birth the exception. Maggie does not accept that caesarean section should become normal, so she will do what she can to prevent it, and to ensure that a woman labours normally or naturally.

Mary, in trying to discourage women from opting for an elective caesarean section, takes this one step further:

I look after a lot of elderly primigravidas and nearly all of those want an elective caesarean because this is going to be their only one. I am talking about forty-year-olds and they couldn't bear the thought of anything going wrong; couldn't bear the thought of losing their child, and although some are quite adamant that they will do a good job of having it normally. There are also others that think, “Look, I'm forty. I'm not going to be any good at this,” and accept it, and you have just got to talk them out of that (Mary).

Mary shares some insight into the views of women similar to those described by Papps and Olsen (1997) regarding the choice of an elective caesarean section. Mary shows that some women do not feel that they are capable of giving birth vaginally or normally, thus reflecting a view that the body is dysfunctional and not to be trusted (Wagner, 1994). They fear that something is going to happen to their child, and need reassurance. Mary tries to talk them out of an elective section if she can, to keep birth “normal”. The need to challenge the decision about an elective section seems to be part of her belief that a woman should labour and at least try for a normal birth.

Mary appears to be in an environment where the view of “normal” for women is very different from that of Gabrielle’s. Gabrielle appears to accept an occasional use of intervention. She describes differences in birth for different women in different contexts:

There is not one way to look after every woman in labour. There are a lot of different ways. What works for one woman might not work for another. Women obviously do have normal vaginal deliveries in outlying hospitals and have home births. At the hospital where I work, women come in and have a lovely normal labour and delivery. They cope, and don’t need those little interventions: things like fluids, or an ARM, or pain relief - but some do (Gabrielle).

Gabrielle recognises the individuality of women and their needs. Guilliland and Pairman (1994) point out that there is skill in midwives’ ability to “recognise each individual’s boundaries of normal” (p.6). This seems to be about not only the physical process of how a woman labours, but also her expectations and psychological response to labour. Gabrielle recognises that not everyone requires intervention. However, she feels that some women may require smaller interventions like fluids and an ARM or pain relief to help them achieve a “normal birth”. The smaller interventions are to lessen rather than to add; to help a woman have a normal birth rather than to hinder. She mentions the different places where women birth “normally”. She is open to the possibility that what seems to be normal may not be so, and what may seem to be abnormal could turn out to be normal.

Kay, like Gabrielle, suggests that interventions may sometimes be necessary to keep birth normal. She shares a story about encouraging a woman to cope without an epidural by using other smaller interventions because she is progressing rapidly in labour. Kay talks about a woman having her second baby, the way that her previous birth experience has coloured her expectations, and how she is coping this time:

She was really, really distressed and quite scared from her previous experience. When she came in she talked about having an epidural like she had with her first baby and was 7cm dilated. It was all happening quite quickly. Everything else

about her was completely normal and I talked to her about other forms of coping in labour: positioning and getting up and moving around, rather than just going straight for an epidural. I talked about gas and Pethidine... She was managing really well with the gas, so I went off to get some Pethidine and left her with her support people.

I came back and she was beginning to get more distressed this time and was getting quite pushy, but she wasn't obviously fully. I talked to her about what we should do and she agreed to have some IV Pethidine, about 25mgs bolus and it just kept her in control. The next thing she SRM'd [spontaneously ruptured membranes]. There was meconium stained liquor and you could see the head right there; like she was just about over the edge and the Pethidine just brought her back enough to be able to be in control and push the baby out and it was given so close to delivery that it was low risk to the baby. I had been monitoring her intermittently prior to this, but once she SRM'd with the meconium present, the head was on view and I monitored the baby until it delivered.

It was good in that she got through that labour and delivery without needing an epidural. Afterwards she felt really good about that, and you know we could quite easily have got an epidural in when she came. But it was, I think, my support and encouragement and I also made sure the support people were really involved and empowered as well to help her. They felt really confident about that. Between everyone, she managed to get through it (Kay).

Kay was trying to get the woman through labour without an epidural because the woman's labour was progressing rapidly. Kay considered that alternative pain relief, 25mgs of Pethidine or a bit of gas, was preferable to the bigger intervention, an epidural. Kay could easily have got the woman an epidural, but she wanted to keep it normal by keeping the woman moving and trying different positions. If the woman had not been 7cm dilated, would Kay have made the decision to get an epidural for this woman? Is it about timing of the intervention, and Kay knowing that it was not going to be long before the woman was delivering? Time as it is lived, in this case, appears to have been quick for Kay, but too long for the woman to cope with the pain of labour, so

she required some pain relief. As van Manen said, time is subjective, and is based on individual perception (van Manen, 1990). The woman's perception of pain is also individual, and coloured by her previous experience (Leap, 1996).

Kay was making every effort to facilitate a happier experience for the woman, as well as trying to reduce the amount of intervention she had, knowing that epidurals lead to increased intervention or the slowing of labour (Howell, 2004). The alternative was to give her a little Pethidine. Kay also talks about the woman "being on the edge" and the Pethidine bringing her back into control. It seems that the woman remaining in control and being able to cope with labour is more "normal" than losing control (Berg & Dahlberg, 1998). There is also recognition of the value of the woman's support people. Supporting women and helping them to get through appears to help keep birth normal, and promote a more satisfactory birth experience (Enkin et. al., 2000). However, sometimes the presence of support people may mean that the woman does not feel that she can lose control, because it is difficult for the spectators to watch and they cannot cope with seeing the woman in pain. Therefore, it might mean that it is more "normal" for those who watch for the woman to remain in control.

Kay was also intermittently listening in to the fetal heart until there was meconium liquor present, and then continuously monitoring the baby until it was born, to be safe. Intermittent monitoring is less interventionist than continuous monitoring. Kay kept the monitoring to a minimum until there was a problem. The meconium was previously concealed, unknown, hidden until it was evident. The "revelation" takes away the mindset of normal and calls for the related intervention of monitoring.

Kay feels that the woman was happy that she got through labour without an epidural. Is this about balancing the need to keep interventions to a minimum to facilitate a normal birth, with the need to give the woman a better experience? Kay formed a relationship with this woman. It appears that the woman was empowered by Kay to decide not to have an epidural. The woman's realisation that she could do it with support and assistance, using more minor forms of pain relief, also seems to fit with Kay's view of keeping birth normal. Kay discussed with the woman what she thought along the way. The woman then feels that she is part of the decision making process, and therefore

feels it has been a better experience (Berg, Lundgren, Hermansson & Whalberg, 1996). Supporting, encouraging and “being with” the woman seems to create a better experience. It also enables the woman to cope without the more intrusive intervention of an epidural.

Kay seems to regard reduced intervention, compared with what it could have been, as part of keeping birth normal within the secondary care setting. Martha also has this view, as she prevents the greater intervention of a ventouse by manually rotating a baby:

A young primip who had been pushing for ages, she had a team midwife and the woman wasn't getting anywhere and had basically given up and they were going to do a ventouse. I was asked to examine her and it was not quite OA so I manually rotated it and we had a nice normal delivery with the next few contractions. If nature ain't doing it then you've got to help her by rotating the head if it's slightly off. A little bit of a twizzle and it doesn't really matter if you rotate it the right way or not it's just getting it off the ischial spines and the parietals and it comes down nicely. Some midwives are too patient and they will wait forever; others are too impatient and expect miracles.

I think being able to manually rotate the baby and flex it for me has saved so many ventouse extractions. Once you have rotated you need six good contractions with pushing, and all right if one is not strong they can have a holiday on that one. But if I don't see really good progress then yeah I'll opt out but not before. One I was going to opt out at four contractions, and I did and rang the registrar and said, “Come and give us a hand,” and then I went back and the head was sitting there nicely. Just shows that it can make a difference and the woman had a normal delivery (Martha).

For Martha, the skill of manual rotation of the baby's head has saved the need for a ventouse delivery. A manual rotation is perceived as being less intrusive than a ventouse, even though they are both interventions. Martha's assistance, through manual rotation, enables the woman to have a normal birth rather than an instrumental. She

does, however, indicate that skill and patience are required for doing it successfully, and that the woman still has to push effectively. There appears to be a “knowing” or experience on her part that enables the woman to have a vaginal birth. Who teaches midwives how to do manual rotations? Is it a skill that predominantly doctors use? Is it an “old” skill that has been replaced by technology? It appears to be a skill that is no longer in vogue; one that may no longer be passed on with the advent of the ventouse. The American Academy of Family Physicians (2000) Advanced Life Support in Obstetrics (ALSO) course indicates that manual rotation can be attempted with a vaginal examination, and if it works, then birth can be expedited, and if not no harm has been done. They point out that it is a “neglected skill and can prevent an instrumental or caesarean birth” (p.5).

Martha uses her skill to assist her woman to have a normal birth. Gabrielle shares her skill of using Pethidine at the right time to anticipate what would happen. Thus preventing other interventions:

A little 12 year old girl I looked after who was very young, very frightened and very anxious and never really spoke English had her mother and her auntie with her. I decided I would look after her because we were quiet on delivery suite and I actually feel I'm quite good at looking after young girls, very young mothers. She was 4cm dilated and already had ruptured membranes. We talked about pain relief and we all decided between us that she would have 100mg of Pethidine. I thought well I'll wait now and she went off to sleep for 3 hours and woke up fully dilated. Over the years, seeing young women in labour, I know they usually do pretty well if the baby's lying in a good position and the head's well down, and I just anticipated that's what would happen and that's exactly what she did. We had the baby and that made me feel really good (Gabrielle).

Gabrielle felt that she provided good care in a challenging situation. She liaised with the family supporting the young girl, and together they agreed on a form of pain relief for her. It appears that Gabrielle had anticipated accurately what would happen for this young girl in labour. It seems that by using the minor intervention of Pethidine, the midwife was trying to prevent the girl having too stressful an experience. This young,

frightened girl had ruptured membranes, and the midwife would know that in this delivery unit she would have to have intervention if she did not progress. It appears that because she had Pethidine, she relaxed and progressed, and did not require active labour management in accordance with primigravida guidelines (Sadler, Davison, & McCowan, 2001). The use of Pethidine therefore prevented further possible interventions, such as the need for epidural and syntocinon augmentation. This midwife kept birth “normal” for the young 12-year-old. It appears that Gabrielle “leaped in” as defined by Heidegger to assist this young girl to have as little intervention as possible in the circumstances (King, 2001). She had an idea about what might be the best option for this young girl, and anticipated what would happen, resulting in a good and normal birth outcome.

It appears that Gabrielle has similar opinions to Kay’s about using smaller interventions to keep birth normal. Kay talks about the use of intravenous fluids assisting a woman to progress in labour:

I find often if things are sort of chugging along a bit a bolus of intravenous fluid helps without being too invasive. Some people would think that was really invasive, but I see often that it does work and you always see women that have their epidurals and they have that bolus of fluid and by the time the epidural’s gone in they are fully dilated. You don’t know if it’s because they have relaxed because they know they are going to get their epidural, or I’m sure the bolus of fluid makes a huge difference to the contractions (Kay).

Kay is aware of different perceptions about what is invasive. “Some people” indicates that her views regarding intervention are socially constructed. She is conscious of what “they” (some people) might think. “They” are no one in particular. They are people of whom we might say, “people think so” (King, 2001). The “they” of Kay’s everyday practice encourage her to think about what she is doing, and whether or not it is appropriate. She has seen women progress once they have had intravenous fluids and relax once they know they are going to have pain relief, then progress in labour. Kay has also seen the effect of intravenous fluids when a woman has an epidural. It appears that the use of intravenous fluids prior to the epidural can assist a woman to progress in

labour and perhaps negate the need for an epidural. Again this is using smaller interventions to prevent bigger ones, and increasing the chance of a woman having a normal birth.

Martha agrees with Kay that fluids and Pethidine can prevent the more intrusive intervention of an epidural:

Women have actually come in with the idea they want an epidural or it's possible they had an epidural the previous pregnancy and feel that they desperately want another one this time. They are going fine, but until you consent to the fact or tell them that you have rung for an epidural they basically stop. If they have some Pethidine and they have a litre of fluid first, but the epidural is coming, they relax. Quite often they don't end up with the epidural because it's mind over matter. They have set their hearts on having it and until you consent to get it they are not going anywhere. You say, "Yes, well have your Pethidine and your fluids," knowing full well that they will deliver first anyway (Martha).

In Martha's experience, just agreeing to get an epidural for some women is enough to encourage them to relax and progress to a normal birth. It appears that it is not just the effect of pain on these women that is preventing them from progressing in labour, and holding them back in some way, but the belief that they cannot do it without an epidural. It seems to be, as Martha says, "mind over matter", a psychological effect of holding back from giving birth. Once the woman thinks she is going to have an epidural she progresses. Martha also uses the smaller interventions of intravenous fluids and Pethidine to encourage progress in labour. Although it is the woman's choice to have an epidural, Martha uses tactics that do not deny the woman what she wants, but encourages normal birth. She creates a perception for the woman that she is getting what she wants, but at the same time, she is doing what she can to avoid the epidural, and keep birth "normal".

Gabrielle, like the other midwife participants, believes that earlier interventions may sometimes encourage labour to progress normally. She shares her experience of a woman being transferred from a primary unit:

A primip who's been contracting for 12 hours and is distressed, hasn't progressed, is transferred in from an outlying hospital or smaller unit into the hospital. You can instantly see she needs pain relief and intravenous fluids and when you have done an abdominal palpation, then actually done a VE and thought, "Well, this woman could have had her membranes ruptured". That's exactly what you do after discussion, and give her some pain relief and some IV fluids and they deliver actually quite quickly and normally (Gabrielle).

Gabrielle seems to indicate that reluctance to intervene to try and keep birth normal can sometimes hold a woman back from having a normal birth. The smaller interventions of an ARM, some pain relief, and some intravenous fluids enable the woman to progress in labour. The transfer to the secondary hospital may have been avoided if these simple interventions had been put in place earlier. She says she can “instantly see” what this woman needs. Is this about the experience of knowing, and being skilled at choosing when to intervene and when not to? Identifying when there is a need for smaller interventions to enable a woman to have a normal birth seems important in keeping birth normal.

Bronwyn, like Gabrielle, indicates that there is a right time for intervention:

I suppose what I have found with the use of intervention is by looking at the end and what you want in the end. You can prevent it before it has happened. So it's the ARM at the right time. It's the pain relief at the right time. It's the bolus of fluids at the right time. Instead, you see people who want to keep everything normal, like the really "normal" people will go so far in the "normal" that they end up with major complications because they end up having done nothing simple before.

People will somehow accept a caesarean at the end of a labour but won't accept an ARM or putting in a drip because it's intervention earlier in the labour. We might have got away from that a wee bit but it is still there with people that are very "normal" focussed. So I think it is actually looking laterally and what does this woman want? Does she really want a caesarean at the end of the day, or is she happy to have an ARM or is she happy to have an IV put in? Even doing a VE, I mean these people who don't do VEs and say that VEs aren't necessary, and it's intervention or it's invasion or all that sort of thing. To me if it prevents a caesarean at the end of the day, then it's not a major intervention or a major invasion of their privacy. I think we have to get that balance and I think some people have lost that balance and they are so focussed on the "normal" that they actually can't see down the track and it becoming abnormal (Bronwyn).

“At the right time” seems to be an important part of keeping birth normal, for Bronwyn and all these midwives. It appears that some midwives might leave the smaller interventions too late and then a woman may end up with a greater intervention like an epidural, instrumental delivery, or a caesarean section. It seems important to identify when labour is no longer progressing normally and is becoming abnormal, and may require small interventions to afford a normal birth outcome. They appear to understand that some women or midwives may not want any intervention, but there needs to be a balance of providing smaller interventions when appropriate.

All the midwife participants are aware of possible technological interventions, especially the major obstetric interventions. To them, keeping birth normal in a secondary care setting means avoiding these medical interventions, perhaps by using smaller interventions at the right time and balancing the use of technology. It appears to be principally about avoiding medical obstetric interventions.

The midwife participants all demonstrate that their relationship with the women is central to their belief in normal birth. This introduces the next theme of “Going along with women”.

Going along with women

The midwives in this study identify that the women themselves have an influence on “normal birth” by refusing interventions like a vaginal examination, or requesting interventions such as an epidural. The midwives then go along with the women, following the cues given them. van Manen (1990) referred to the “lived other” and our relation with others within “the interpersonal space that we share with them” (p.104). Midwives are directly affected by the women themselves, and often feel that they have to go along with women, even though it sometimes conflicts with their own midwifery decision making or beliefs.

Sally talks about a young 15-year-old primigravida of Maori ethnicity. She has concealed her pregnancy and has had no antenatal care. After suspecting she was pregnant and in labour, her family brought her into the delivery unit of the obstetric hospital:

The midwife who had been looking after her previously had examined her and found her to be 3cm dilated in active labour with fore-waters present. The young woman was very, very quiet, wouldn't really speak to you and didn't make any eye contact. It was difficult trying to get a rapport with her... she either lay on her side or on her back with a face cloth over her face. She would let you monitor the baby but she refused any more vaginal assessments. She wouldn't let you look below the covers or anything so it was very difficult...I was trying to go along with her wishes. If she didn't want a vaginal examination that was fine. There were other signs that told me she was in good labour. I was trying to gain her trust.

...I knew she was in advanced labour. I felt intuitively that yeah it was OK not to do a vaginal assessment and that she ought to deliver. Her grandmother said, “I think she is going to have the baby. She has been bearing down.”... The girl herself wouldn't let her grandmother or her mother look. I explained that at some point we would have to remove the covers and see if the baby's head was there. She was on her hands and knees and we just gently lifted the covers while

she was pushing. There was a heavy 'show' present and the vertex was visible in the distance and she pushed out a lovely baby girl.

It was such a thrilling experience for me because she was a young girl. We hardly had any communication between us; she was unbooked and a concealed pregnancy but there was some sort of rapport there and she trusted me. I knew instinctively that she was progressing. I felt very humble going more on your observations and your skills as a midwife and not having to rely on doing a vaginal assessment. I thought, "Yeah, that's what it is all about." The young woman still didn't say much but she just smiled and said, "Thanks." That's about as much as she really said to me but it really meant a lot (Sally).

A concealed pregnancy is a real challenge. Sally indicates it was not easy building up a rapport with the young woman in labour because she did not want to communicate. Sally goes along with the young woman's decision that there were to be no more vaginal examinations. Is it because she does not allow any further intervention that she herself keeps her birth normal? Sally can see that there are other signs that she is progressing. Sally brings the young woman to the centre of her care and goes along with what she wants. This may have not been achieved with a different midwife who may not have felt she could go along with what the young woman wanted. The "high risk" nature of the young woman's pregnancy in medical terms may have meant that she required close monitoring and medical control (Wagner, 1994). What are the midwifery skills that Sally uses instead? It seems to be about "knowing the signs" of a woman progressing in labour, and the need for patience and trusting in the normal birth process (Leap, 2000).

Perhaps it is also about keeping the young woman safe, because further vaginal examinations would have been a violation or an intrusion for this young woman, despite the "normalisation" of such routine examinations (O'Loughlin, 2000). There are issues of ethics and consent. When "doing" research the researcher is mindful about being respectful to the participants by maintaining confidentiality and gaining consent. The midwife is aware that in her everyday "doing", the woman does not consent to further examinations and therefore maintains respectfulness (Smythe, 2002). The New Zealand

College of Midwives' (2002) handbook for practice states that the midwife should respect "the woman's right to decline treatments or procedures" (p. 9). Sally demonstrates true woman-centred care. Although she is likely to be aware of the policies and protocols of the hospital where she works, when this young woman refuses her consent, she is able to let birth be, to unfold without intervention.

Perhaps this young woman unconsciously kept birth normal. Women's confidence, and their expectations of labour and birth can assist midwives themselves to trust in the normal birth process. Sarah tells a story about a woman she looked after during a busy duty. It was the woman's third baby and she did not think the woman was in established labour:

...She'd been examined in antenatal clinic and she was 3-4 cms. So I said, "OK, I'll leave you to cook for a few hours and see what you're doing". In context, I was busy with another woman, so that was keeping me out of her room anyway. I remember the charge midwife saying to me, "Have you put a luer in her and taken a group and hold yet and what does the CTG look like?"... I thought to myself, "Well, actually, it's this white machine in the corner of the room, and it hasn't been anywhere near the woman," (laughter). "Yes I have listened to the fetal heart and it's fine." "Are you sure she is in labour?" ...there was this constant sort of dialogue of what's going on with this woman. I thought, "I'm just going to ride with whatever's going on here."

As I entered the room she sort of gave me a funny look. I don't know, it was just an odd expression and she said, "I'm just going to the loo." I said, "Yeah sure," and something went ping in my brain. I thought, "Oh hang on, perhaps I should follow her with a pair of gloves."... baby was on its way. So it was just as well I was right behind her (laughter) and we had her baby over the toilet. Honestly, if I hadn't been there she would have just carried on and done it herself. The woman said, "It was fantastic, this is how I have babies. This was great. Oh thanks for the towel. You were so wonderful. Thank you for leaving me alone. You were fantastic." I thought, "I didn't do anything," and spent my time with another woman who was doing it all very normally with syntocinon,

epidural, CTG and the whole lot (sarcastically). Meanwhile “normal” was carrying on under my nose completely unbeknown and unrecognised to me.

I came out and said, “Oh we’ve had our baby” to the charge midwife and she said, “Oh, oh, oh really oh, OK.” Yes, she was surprised...I sort of omitted to mention the fact that we nearly had the baby down the toilet. The woman so trusted her body, knew her body and just went with it. There was no hint of fear. It was, “It’s going to happen; it’s going to be OK”... I think it’s fantastic, and she probably did a lot to empower me as a woman and as a midwife in that delivery. It taught me that she is the opposite extreme from the women who come in demanding elective sections or epidurals at the first contraction. I guess it all comes full circle, it’s a give and take thing and I get a lot of encouragement and empowerment from women who show me that normal childbirth is a reality. Then that energises me to give back to the women who need the conviction of their own strength (Sarah).

Sarah was not sure what was happening with this woman in labour, so she left her alone and waited to see what was going to happen. She did not “leap in” or take over. Smythe (2002) talked about Heidegger’s understanding of “being-there-with-others”, in terms of care or concern. He refers to “leaping in” as mentioned previously, when care is taken over from the other. “Leaping ahead” is when care is not taken away, but goes ahead so that the care is given back to the other (p.173). Sarah resisted the expectation that she should put a luer in the woman and tie her to the fetal heart monitor. She left the woman to walk around. She did not take away the woman’s independence, but she “leapt ahead” by leaving the care and the labour within the woman’s hands to follow its own process. Perhaps because of the other demands on her time she had no choice but to free this woman to have her own experience. The woman was confident of her own abilities, and transferred this confidence to the midwife.

The dialogue between Sarah and the charge midwife reveals certain expectations regarding looking after a woman within this secondary care setting. In this hospital the Sarah indicated that women are expected to have an admission fetal heart tracing (CTG), and women who have their third baby or more are to have a luer inserted for

intravenous access. Yet, Sarah felt that the woman appeared to be in early labour only, and she did not need to “leap in” at this point. She thought, “I’ll just ride with whatever’s going on here.”

The woman empowered Sarah to keep it normal. The woman said, “Thank you for leaving me alone. You were fantastic,” which indicates that it was a mutually satisfying experience for both the woman and Sarah. Sarah did not see that “normal” was going on all the time because she was not there. Maybe Sarah realises that if she had had time for the woman, she may have felt obliged to go along with the expectations of the secondary setting and therefore altered the experience for the woman and Sarah. Sarah feels that this woman has encouraged her to have patience, to watch and wait to see what is happening rather than “leaping in”. The woman has given the confidence to the midwife to keep it normal, and “not being with the woman,” meant that intervention did not take place. Sarah observes that there are women who have different views about birth from the woman in the story. These women need support and encouragement to believe and trust in the normal birth process. Some women may not have the view that normal birth is what is important.

It appears that midwives following the cues from women can assist both the women and the midwives to persevere with labour when the chances of a “normal birth” appear slight. Gabrielle is in charge of the delivery suite, and recalls the experience of a young primigravida woman:

A young woman came in. She was short and had a very large baby and she was in labour. She wasn't progressing very rapidly and we did think, "Section her. She'll never do it."... She'd had an ARM following the primigravida guideline. She definitely did not want any pain relief. She was a very positive person and she had a very positive family and so they plodded on and took a long time. She got an elevated temperature and had meconium liquor.

She eventually had an epidural and she was progressing still very slowly with syntocinon. She developed some fetal tachycardia and we thought she'll definitely be a caesarean. It's just a matter of time. We just have to give it some

time... she was very positive that she didn't want a caesarean. She was a bright woman and she responded well to her midwifery carers and the medical people but she was quite determined. She had been in early labour, when I commenced my duty. When I was going off a 12-hour shift at approximately 7 o'clock she had a temperature of 38.4 and by that stage I was saying, "Please take her up for a section." I don't know if I'm supposed to say that but she was fully dilated not long after, and when I went back the next morning she'd had a normal delivery and her baby was 4060g. So it took patience. It was a lot of time; it took a lot of time. I wasn't very patient obviously. You never stop learning. You never stop.

I think this woman influenced her outcome because she was very positive. The midwife caring for her actually built up a rapport really quickly and you could see they just clicked. I think, maybe, the woman would have had a caesarean if she and her family hadn't been so positive. The rapport between the midwife and the family was brilliant and when we went in there, you actually felt like you were interfering and well they probably both really influenced the outcome. But the midwife thought that the woman would have ended up with a caesarean section too. She is very experienced but that woman was really sure she didn't want to. She was going to do it all by herself, vaginally, normally (Gabrielle).

Gabrielle feels that the woman influenced her birth outcome by being so positive and clearly indicating that she did not want a caesarean section. Does this mean that the midwives and medical practitioners were prepared to give it more time because the woman was so determined? The relationship between the woman and the midwife appears to have been very important as they had very quickly built up such a bond that others felt that they were interfering. Was this a protection of the woman by the midwife to enable more time and facilitate a "normal birth"? Some may argue that the woman had so much intervention, in the form of an epidural and syntocinon that she no longer was having a normal birth. Yet the woman perceived that she had given birth normally, vaginally. This woman was determined to deliver normally. Had she been unsure of what she wanted, perhaps the outcome may have been different. If the

midwife had not supported the woman in what she wanted, by encouraging her to give up, would she have been so determined?

Allowing more time seemed to be the result of the woman and the midwife working together, to try and achieve a normal birth and guarding against the medical practitioners from intervening too soon. Time, as it is experienced by Gabrielle, is time that seems too long (van Manen, 1990). As time appears to slow Gabrielle becomes more anxious about the woman. Yet she eventually realises that giving the woman more time is what has assisted her to have a normal birth. Patience sometimes results in the success of a normal birth, even when the odds seemed stacked against this.

In contrast to Gabrielle's story, Sally talks about a woman that arrives in the delivery suite in good labour with her second baby:

She didn't want any pain, and could we get the epidural as soon as possible. I told her that she was 5cm dilated, and asked her what the pain was like for her. She said she had some backache. I offered the heat pad, or to try walking about, or try going on her side to relieve the pressure on her back, or hands and knees, or try some Pethidine. But no matter how much coaxing I did, she still said that she wanted this epidural.

I expressed to her, "Look, it is your second baby and the birth is probably going to be a lot quicker than your first. It will be a lot different". I felt she could get through without it, but the more and more I discussed this, she was not pleading but she was getting defensive by this time wanting an epidural. So we did actually get her an epidural. Within an hour she said that she felt some rectal pressure and so I said, "That's great," and I examined her and there was just a very thin anterior rim and the head was at the spines. Ten minutes later she ruptured her membranes and the vertex was visible and shortly after she had a normal delivery.

What stuck out was that she was so grateful to me for getting her this epidural although deep down I knew she didn't need it. She just said that she felt that I had listened to her and had taken into consideration her choice. She thought that had made the difference to her labour... So it's not always what you think is best for the woman. Sometimes in circumstances like this you've actually got to take on board what they are telling you and what their choices are and just say, "Right, OK. We'll do it that way." (Sally).

Within Sally's beliefs about keeping birth normal, she minimises intervention by helping women to work through the pain in labour by using other forms of pain management. However, this woman will not be cajoled into coping without an epidural. The woman believes her experience is better because the midwife listened to her and facilitated her request for an epidural. The woman's choice appears to be at the centre of the decision making (New Zealand College of Midwives, 2002). The midwife went along with what the woman wanted even though she did not think it was needed.

Had the outcome been an abnormal birth, would it have made any difference to the woman's perception of the experience? Would the midwife be feeling that she should have been more forceful? The interaction between Sally and the woman, as van Manen (1990) observes, "is lived in relation to the other" (p106). The midwife-woman relationship is formed and dependent on "the other", and affects how each one interprets their experience. The midwife recalls the experience because of the inner conflict it created for her professional or clinical decision making. She appears to recall this story to show that "the other", the woman herself, had a powerful influence on her experience of trying to keep birth normal.

In relation to the theme of "Going along with women", the midwife participants in this study acknowledge that women influence their practice in a positive or negative way in relation to "keeping birth normal" - with or without intervention. Working with women and helping them to have a birth experience that is all right for them, means that midwives sometimes go along with what the women want and the women themselves will keep birth normal. Thus the midwife may be restricted in keeping birth normal because of the "other" - in this case, the women themselves.

Summary

This chapter, “Stepping Back or Stepping In” illustrates what Heidegger called “leaping in” and “leaping ahead”, in relation to the care of others (King, 2001). To leap in or leap ahead for others’ care is similar to the midwives making a judgment about when to step back or step in, in that they have to decide, when caring for women, and advising or teaching students and junior midwives, whether they should intervene or not. Sometimes they may need to take over the care and “leap in”, and at other times they try and give the care back to the woman, or junior midwife. They highlight the complexity of trying to not only keep birth normal, but also to assist the woman to have the experience that she wants, while assisting the more junior midwives to gain experience in clinical practice and learn how to keep birth normal.

“Something minor to prevent the major things” is also a theme presented about stepping back or stepping in, when judging if a woman requires intervention for the progress of labour or not, and the possible prevention of caesarean section, instrumental delivery, or having an epidural. The participants are also trying to reduce the amount of interventions that occur and are always thinking about a woman having less intervention than what could have been.

“Going along with women” illustrates the midwives’ focus on placing the woman at the centre of her care. The women themselves show a determination to keep birth normal, or alternatively, they request intervention. The midwife may not necessarily agree with the choices that they make, and may try to influence them to try something different, but they realise that it is ultimately the woman’s choice. The midwives step back or step in, depending on the wishes and needs of the women.

Throughout this chapter “time” is a significant factor. Judging when interventions may be needed “at the right time” is what also influences midwives to step back or step in. To allow more time for normal birth to occur without intervention or to intervene at what is deemed the appropriate time to allow normal birth to occur. Time speeds up or slows down for the participants depending on what is happening. They are aware of the

social and historical influences that have meant the length of labour is expected to be shorter, taking “less time” a lack of patience for birth to unfold. Within the secondary care setting midwives are mindful of running out of time before medical interventions will occur.

CHAPTER SIX

Interacting with the doctors

Introduction

Large secondary and tertiary hospital facilities with 4000-8000 births a year are staffed with medical and midwifery personnel. In these situations, the “lived other” (van Manen, 1990) for the midwives is experience as it is lived in relation to doctors. They not only share the same workspace, but they relate in a clearly defined hierarchical manner. The obstetrician is deemed to have ultimate responsibility for the care of the women, their unborn child and their safety (Crabtree, 2002; Johanson, Newburn & MacFarlane, 2002; Kirkham, 2000; Wagner, 1994). Historically, socially and culturally the relationship between midwives and doctors has been at times challenging because of differing views regarding childbirth, as indicated in Chapter Two.

When working in a secondary care setting it is inevitable that decision making by the doctors affects the midwives and their experiences of keeping birth normal. The participants demonstrate different facets of the midwife-doctor relationship that influence the birthing process. There appear to be four different ways that the midwives in this study relate to the doctors within their setting: the midwives may at times “hide the women” from intervention; they may become “caught”, or trapped, into decisions that have been made by the doctors; they may influence, guide or manage the doctors towards their way of thinking; or there can be a camaraderie between medical and midwifery staff that enables teamwork to occur.

Hiding the women from intervention

The midwife participants reveal that at times they keep women away from the doctors, hiding them or guarding them from possible medical intervention to try and keep birth normal. Sarah shares her experience with a grand multiparous woman:

She was having her thirteenth baby and we fought to keep her normal because the doctors were so scared about PPH [post-partum haemorrhage]. She had

no historical problems whatsoever. All of her babies were normal vaginal deliveries. This time she came in a bit earlier than normal and eventually confessed that the other kids had been playing up a bit and there was no bread in the house. It was really hard having a grand-multip on the premises who really needed a social break, without doing stuff to her and trying to keep the doctors out of the room because she was interesting.

The registrar was particularly jumpy and would have just sectioned her at the drop of a hat because he was so nervous about what might possibly happen. The woman was quite happy and was very used to the routine but she was uncooperative until she had her food and her sleep and her favourite auntie in to be with her. She knew exactly what she wanted and it was very normal for her and we let it happen. She said, "I'm going to have my baby now," and two pushes later there was baby.

I told the registrar a while afterwards that she had delivered and he said, "Oh good and how big was the PPH?" I said, "What PPH?" and he said, "Oh". He frankly sounded disappointed really. I said, "Everything's fine. Her uterus is rock hard like a grapefruit and now she's going home". He said, "Oh no she should stay in". There was no way she would have stayed in and she didn't want to stay in. I said, "The best thing you can do for this woman is to get her booked in for a tubal ligation," which is what she wanted. She said, "Can I come back tomorrow and have my tubes tied?" I said, "You can stay overnight." "Oh no, no, no I'll come back, I'll come back," and she walked out of there with half a dozen kids trotting on after her (Sarah).

In order to keep birth normal for this woman, Sarah seems to feel she needs to protect her from the doctor and possible intervention. She says she "fought to keep it normal" like a battle that needs to be won. The woman came in earlier than she normally had done; therefore there was more time to carry out interventions. Maybe the more time that doctors have to think about intervention the more likely it is to happen. Perhaps this doctor had too much "time"; therefore he was available to intervene. It does seem that the longer the woman is in delivery suite before she is established labour the more

likely she is to have intervention. Hemminki & Simukka (1986) found that women who came to hospital too early received increased intervention. This is also supported by McNiven, Williams, Hodnett, Kaufman and Hannah (1998) who found that women who were encouraged to mobilise off the labour ward, or who were sent home, had less pain relief, a better experience, minimal intervention, and shorter labour. In Sarah's opinion, the woman's situation was normal until it was shown to be otherwise. She wanted to keep birth normal by protecting the woman and creating an environment, a space, to let normal birth happen. To achieve this it seemed necessary to keep the doctors away. Is this about different models of care or different perspectives? The doctor was almost anticipating that the woman was abnormal until she proved herself to be normal. He wanted her to stay "just in case" anything should happen. However, it is perhaps understandable that doctors are anxious and err on the side of caution. If the woman did have a severe PPH (post-partum haemorrhage) it would have been the doctor who was called to attend to the emergency.

Bronwyn has a similar experience. She shares her story about a Pacifica woman who had had a previous caesarean section. This woman had been told by her caregiver to come into delivery suite as soon as labour started.

This woman does what she's told. She comes into delivery suite probably about after her 4th contraction. I assess her; she's not in established labour. I said to her, "Now go outside for a walk and I don't want to see you for an hour." Soon after she had gone the registrar comes down [to delivery unit] and said, "You haven't got that lady on a monitor." I said, "What lady?" She said, "That lady there. She is a previous caesarean section." I said, "She is not in labour." She said, "Oh but she should be continuously monitored. She's a previous caesarean section." I said, "I will monitor her when she is in established labour." Anyway, the woman came back in an hour and I did her recordings and said, "Right, I don't want to see you for another hour. You can go to the café or whatever you like but don't come back here," (laughter).

The registrar came back to me and said, "Huff! Have you seen that lady?" And I said, "Yes I've seen her and she is fine." She said, "What will I tell the

consultant? She'll want her continuously monitored." The registrar was really nervous. I said, "Well rub her name off the board and she won't know she is here," and she looked at me! Every hour the registrar would come to me nervous as. Luckily the woman got into established labour about three-and-a-half hours later and I monitored her and she delivered within the next two hours.

Now if that was a junior midwife she would have continuously monitored that woman on the bed probably. Performed an ARM too early. Then she might not have been put on syntocinon because she was a previous caesarean and therefore could have ended up with another caesarean. It was a junior registrar and she knew me. In one way she wanted to trust me, and in the other way she was scared of what the consultant was going to say. It was just my ability to say that she is not in established labour but I will monitor her when she is (Bronwyn).

Bronwyn obviously wants to keep the labour as normal as possible, only intervening if necessary. Again, timing appears to be an influencing factor: the woman came in at the "right time" as she had been told; Bronwyn thought that "the time" was too early; and the registrar thought it was "time" to start intervention (monitoring), feeling duty bound by expectations or protocols. "Time" as it is lived for all these people is different and subjective (van Manen, 1990). The registrar is possibly afraid of what the consultant will say. It appears to be a very defensive way of practising. Bronwyn seems to be "hiding" or "guarding" the woman from the registrar. Perhaps as a sign of Bronwyn's frustration she tells the doctor to rub the woman's name off the board.

Bronwyn is "hiding" or "guarding" the woman from intervention by the registrar, who is nervously "hiding" the lack of monitoring from the consultant, and in the end Bronwyn suggests that rubbing her name off the board will mean "out of sight, out of mind". In a sense, Bronwyn and the woman are walking a tightrope. It is the midwife's task to keep the process in balance, and get the woman to the other side of the rope that is a normal birth. Yet from the registrar's perspective, there is an expectation that something is going to happen, and at any moment she could fall into the net below.

Bronwyn is very aware of the effects of a possible “fall”, and the consequences for the registrar and the consultant. However, confident of her own skill and practice, she ignores the pressure on her to monitor the woman. She suggests that a less experienced midwife might feel obliged to go along with the registrar’s wishes, which would have increased the likelihood of intervention.

Martha, like Bronwyn, wants to prevent unnecessary intervention and keep birth normal. She shares her story about doctors wanting to artificially rupture the woman’s membranes to augment the labour:

We had a woman a while ago where they instructed me to do an ARM on a grand-multip and I didn’t feel it was necessary as she had been doing well. She was progressing relatively slow but no slower than her previous labours were. I was told to go and do an ARM and I said, “Sorry, the woman doesn’t want an ARM.” The registrar said, “Well the consultant has said she is to have an ARM and go back and do it.” So I went back to the woman and said, “Go for a walk. The registrar is coming down to break your waters.” So she went off for a walk and not a great deal of time later she spontaneously ruptured her membranes and we had a nice normal delivery. The head had been high and I didn’t see that there was any need to interfere; she had progressed. They wanted to do an ARM because they wanted to see the colour of the liquor. The CTG was fine. What difference does the colour of the liquor make? We should be ready to suction baby for meconium anyway and if there is liquor there well good.

The doctor said, “You sent her away.” I said, “She didn’t want her membranes ruptured. There was no need for it and the head is high and we are just not doing it.” “But you influenced her not to want her membranes ruptured.” You know membranes will rupture on their own, even though 90% of women will say, “Well the doctor always breaks my waters.” The woman hadn’t had that happen in the past and she wasn’t really prepared to have that done to her. Whether it would have altered the outcome I don’t know. You can’t do the same one twice. The woman was chuffed, just to do it naturally without interference (Martha).

Martha, like Bronwyn, wanted to hide the woman from the doctors and intervention. It appears that Martha had a belief in the woman having a normal birth, and wanted to give her more time to labour naturally on her own. “Time” as it is lived for Martha in this case is time that needed to be longer to allow birth to unfold naturally (van Manen, 1990). The amount of time a woman should be in labour has been debated, and through Friedman’s (1955; 1956) research, it became medically controlled. Some feel that the restriction of time in relation to progress in labour abnormalises too many women, many of whom do not strictly conform to his research findings that justify the need for increased intervention in childbirth (Beech, 1998; Murphy-Lawless, 1998). Later studies have found that there is a need to allow longer time for women to progress in labour than Friedman had first suggested (Albers, 1999; Zhang, Troendle & Yancey, 2002). The expectation that labour will be shorter has meant that the doctors will leave a woman alone for only a short time before deciding that she needs some medical intervention. The expectations within a secondary care setting mean that sometimes there is not enough patience to watch and wait for birth to unfold. There is a feeling of running out of time, because there will be a need for intervention.

Martha sends the woman for a walk to avoid intervention. The doctor’s challenge to her about the ARM indicates tension between them, highlighting their different aims and philosophies about normal birth. Are the doctors caught up with a different time scale, feeling that the woman is making slow progress according to their guidelines, with the “risk factor” of a high head? Martha feels that the woman has made adequate progress and needs to be given a chance to do it by herself without interference. Does Martha “know” that the woman can do it, because of her experience and knowledge of normal birth, and is therefore prepared to push the boundaries? She certainly stands her ground by making an autonomous decision, refusing to conform to the hierarchical structure, which would have required her to obey the doctor. She is willing to take the risk, and to face any possible challenges after the event. Could a less experienced midwife “hold her own” in a similar situation? If an independent midwife had consulted with a doctor for advice, would she have felt obliged to comply?

The lived “other” or relationality between the midwives and doctors as they share interpersonal space appears to be difficult at times, depending on the perspectives of each. (van Manen, 1990, p.104). Wagner (1994) stated that within the medical model, “Labour is a time for even closer medical control, to provide quick assistance when trouble develops and before things get out of hand” (p.31), whereas the social (midwifery) model of care regards the psychological and social effects upon a woman during birth as being just as important as the biological ones, and the woman’s “satisfaction” is of central importance (p.33). This sums up the differing views of Martha and the obstetrician and registrar.

Midwives “caughtness” with doctors decisions

The doctors have sometimes already made decisions regarding the care of women in childbirth. The midwife participants subsequently feel their ability to keep birth normal is difficult, and is almost taken out of their hands. They are “caught up” in the process.

Sarah shares an experience of looking after a primigravid woman with ruptured membranes that appeared to be a very small hind water leak. Twelve hours after her ruptured membranes the woman is told to come back at eight o’clock in the morning ready to have her baby:

It was a shared care situation with a GP and we provide midwifery care. The GP couldn’t even touch her cervix it was so posterior. He discussed with the consultant as to what he wanted to do. I suggested that perhaps she should be given prostins and sent to the assessment unit and just left to bide her time and the consultant said, “No. Start Syntocinon.” So we plodded away on syntocinon and she got from a completely unfavourable cervix to 2cms and still a centimetre left to efface in ten hours. At nine and a half hours her forewaters finally went. Unfortunately her cervix had been so unfavourable they couldn’t assess if she had forewaters intact or not. Initially the baby was happy with the whole process. I returned 12 hours later to find that she had an epidural and they had been putting up with fetal distress for quite a while. She had been on syntocinon 24 - 28 hours. The woman was absolutely exhausted and to cut a long story short she ended up with a caesarean section at eight centimetres for

failure to progress. She had antibiotics and her temperature was steadily climbing along with the fetal heart baseline and it was all just a pile of shit.

Had they left her alone and sent her home for another day she could probably have done it herself or given her prostaglandins, got her mobilising, kept her adequately hydrated and given her decent nutrition. Always in the back of their minds was, “We have interfered now. She possibly could go for a section so we don’t want to feed her,” and all this sort of thing.

I felt stink and angry that I was in a very disempowered position to actually fight for her and challenge the consultant because we were working in a shared care environment. All the decision making process and all the power was held by the doctors, the GP and the consultant. I was just the handmaiden that carried out the instructions and I felt I knew better or I felt I knew different and would have managed it differently. I may well have been wrong. She may still have gone for a caesarean section at the same point in time and labour wise. But I think she would have had a nicer experience in the intervening 28 hours: a more friendly to her own body experience. So I was very sad; I was very disappointed. It’s really hard to reconcile your own practice when things like that happen. I wondered, “Could I have done things differently? Could I have fought harder? Could I have spoken to different people? How else could I have affected what happened?” (Sarah).

In this situation Sarah is “caught up” in the decision making between the consultant and the GP, and she no longer has any autonomy. It has left her asking a lot of questions about what she could have done to avoid this situation for the woman. Stafford (2001) suggested that control by the medical profession undermines midwives in their professional role. It is suggested by Campbell (2000) that it is the secondary care midwife’s role to support the LMC and the woman, to ensure the woman’s experience is “the best that it can be” (p.189). Perhaps the tension arises here when the midwife feels that the woman could have had a better experience and perhaps the woman was not aware of the different choices she could have made. Johanson, Newburn and Macfarlane (2002) questioned if women really receive “value-free” informed choice (p.

893). Do these experiences make midwives want to give up? Stafford (2001) suggested that a lack of autonomy may certainly make a midwife want to give up. Kirkham (2000) stated that “midwives cannot empower women where they themselves are disempowered” (p. 232). She has found that the dominance of the medical profession over midwives within institutions has resulted in their oppression and therefore they are undervalued (Kirkham, 2000). However, Campbell (2000) identified that there is an “historical assumption” that secondary care core midwives are employed, and therefore do what they are instructed to do. She points out that although they are employees they are also “autonomous health professionals just as LMC midwives are” (p.193). Perhaps then it comes down to the culture of the institution, and the relationships between the health practitioners and the individual philosophies of each professional (Downe, 1998; Oakley & Houd, 1990).

Maggie, like Sarah, also looked after a woman who was being induced:

A woman that I cared for came down to delivery unit after being induced at 41 weeks for just post dates. She came down to delivery suite after an ARM at 1cm. I don't know how that happened, but it did. She had her epidural probably because the ARM was so painful she needed pain relief and started syntocinon. I don't think this woman was ready for labour for many reasons, both psychologically and physically. She had an OP baby and got very stuck at around 6cms: no progress at all. I did the usual things as best you can with an epidural trying to get her to get in different positions to try and turn baby. It wasn't a particularly big baby. She was an average size woman and I don't think there were any issues there of CPD [cephalopelvic disproportion]. She ended up a caesarean eventually after flogging the labour for longer, for failure to progress - not even fetal distress - after I went off duty.

I think it is difficult because had she been prepared for what labour was all about she wouldn't have had an epidural so early. I think having that epidural in completely flagged her labour that wasn't going to happen anyway at 1cm with an epidural. It completely stopped everything that potentially would have happened. Even though we started syntocinon there was also no time given for a

latent phase. So you have a long cervix at 1cm with an OP [Occipitoposterior] baby and you have got to give time for a latent and active phase, which didn't happen. It all got mingled into one. Once you've got your epidural in that's when the clock starts ticking and that's not when it should start ticking. The epidural in my eyes shouldn't have gone in, in the first place. 12 hours and that was it; it was classed as failure to progress. So she ended up a caesarean and I think that could have been avoided. I think that her labour could have been managed more effectively and maybe an induction was the wrong thing to do in the first place. So you know you are always going back one step. Once you have got them in your hands a lot of things are too late (Maggie).

Again there seems to be a sense of feeling “caught”. The decision about the woman’s labour has been taken out of Maggie’s hands. She seems to feel that once the women are in her care a lot of things are too late, and she has to do the best she can under the circumstances. Maggie finds herself in a situation that she feels could have been avoided. Wagner (1994) identified that as reasons for induction of labour expanded, for example from 44 weeks’ gestation to 43 and then 42 and now 41 weeks, “the benefit weakens but the hazards remain constant” (p.146). These hazards are the resultant need for more intervention such as a significant increase in the need for pain relief, fetal monitoring, slow labour, maternal exhaustion, and the need for instrumental or caesarean birth. Maggie also refers to the clock ticking, the timing of the intervention and a lack of patience. Again, as other participants have showed, time as it is lived for Maggie is too short for giving time and having patience for birth to unfold. van Manen (1990) stated that “time acquires qualities that turn eventually into positive or negative memories” (p.106). It appears that the “caughtness” of being in this situation means that this birth is viewed in a negative way for Maggie, and in her view the medical decisions that have been made have resulted in the birth being abnormal. It is no longer possible for Maggie to facilitate a normal birth for this woman.

Bronwyn also shares a similar experience about a woman being induced and having an early epidural:

Well this woman was being induced for what I would consider a very minor, weak reason. It was a term baby or it might have been forty weeks and three days: that was probably the reason. She had the epidural put in at 1cm and then she had the ARM and then of course she wasn't going to go into labour. So we put up the syntocinon and then we ended up with some fetal distress, not severe, but I think the fetal distress was due to everything that we had done. Then we ended up with an unnecessary forceps and not a nice forceps delivery either. It could have been the operator but not a nice delivery. It is actually quite difficult to diagnose labour or established labour when you have got an epidural in beforehand. So I think inducing this woman with no reason and putting an epidural in before she was in labour and then putting the syntocinon up was all totally unnecessary. It wasn't a nice delivery and I don't actually know how the woman could actually think it was a good idea (Bronwyn).

Bronwyn seems to feel that there needs to be a very good reason to intervene with an induction, for the experience can be most unsatisfactory, involving a series of interventions. Bronwyn was “caught up” in the process. She points out that after the woman was induced they did not wait for her to establish in labour before she had an epidural inserted. Then the woman’s membranes were artificially ruptured when she was not labouring. I get a sense here that the process is very mechanical. It also seems to be more about “management” of the labour in that the medical staff do this and do that, and so “do” the syntocinon, than allowing a natural process to happen. Bronwyn is disappointed. She has little control over what is happening, other than to do the tasks. She believes that the baby was not ready to be born, and becomes distressed as a result of all the intervention. Walsh (2002) suggested that “normal midwifery is determined by structures and people”. Those leading the service for women should be “philosophically committed to the promotion of normal birth” (p.12). Most of the studies in relation to postmaturity suggest induction after 41 weeks’ gestation, and most of them are concerned with neonatal outcomes as opposed to the process of induction and its effect upon the woman (Hollis, 2002; O’Conner, 1994; Sanchez-Ramos, Olivier, Delke, Kaunitz, 2003). However, Alexander, McIntire and Leveno (2000) found that induction of labour between 40 and 42 weeks increases labour complications and operative delivery without significantly improving neonatal outcomes.

Bronwyn cannot understand why the woman thought that induction was a good idea. Is that because she knows the labour experience could have been much better for the woman? Should practitioners explain more clearly what can happen with an induction, and assess more clearly whether it is absolutely necessary to promote normal birth outcomes? Should health professionals just do what women want, and induce them if they are too tired of being pregnant? Is there pressure on the practitioner to agree to an induction? Was it about the woman having control, wanting to know that she would have a baby within the next few days and wanting to have a part in the decision making? How would the woman have felt after the experience? What messages are practitioners giving to their clients when they make clinical judgements that promote a cascade of intervention? Is the decision making by practitioners affecting normal birth outcomes? Once the decision to induce is made it appears to have an ongoing effect for midwives, women and their babies. The “caughtness” that Bronwyn felt in this situation seems contrary to her philosophy of normal birth. It also demonstrates how hard it is to keep birth normal once decisions have been made prior to the midwife’s involvement.

The “caughtness” for the participants arises out of conflict with their own philosophy of what birth should be like for women, or perhaps what they see as best practice. To summarise, as Maggie states: “once you have got them in your hands a lot of things are too late.” When medical management means that the midwives no longer feel they can assist women to achieve a normal birth they feel a “caughtness” in the situation. The medical decisions that have been made mean that a woman is exposed to a cascade of intervention, over which the midwife has no control. There is an alternative, however, which is that the medical and midwifery practitioners work as a team to afford a normal outcome, which will be discussed after the next sub-theme, how the midwives will try to influence doctors towards their way of thinking.

Influencing the doctors

The midwives share their experiences of influencing the doctors to a point where they manage or guide different situations in accordance with their own way of thinking and

practice, to try and achieve a normal outcome. Mary relates a story about a woman who was close to having a caesarean section:

This lady was a gravida ten, para six and was induced at 38 weeks gestation for intrauterine growth retardation (IUGR) and reduced liquor. All her other babies were nine or ten pound. She got to full dilatation with a very high head. I couldn't work this out because all her other babies were quite big and this was supposed to be IUGR. The registrar came in and asked to examine her and I said, "Fine." The registrar said, "This head is quite high. We will have to do a caesarean because she has been fully now for x amount of hours." The woman didn't have an epidural because she didn't want one and she didn't really need one. I said, "Well I'm just going to check that vaginal examination (VE) because I'm not happy for you to do a caesarean on this woman because she has had all these big babies and why is it not coming down?" So I did a VE and for some reason that was my first VE (for this woman). I think I was in charge that day. I could hardly get my fingers in she had such a full bowel; she was so constipated. So I said to the registrar "Right, just let me do one thing before she goes to theatre: let me give her an enema." The registrar said, "You can't give her an enema. She is so distressed." I said, "No I'm going to give her an enema." The woman was quite happy with that so I gave her an enema, got her out of bed and sat her on the pan. She had an enormous bowel action and I didn't get her back on the bed in time: she just delivered there and then (laughter). So that will never leave me!" (Mary).

Mary did not just accept the VE findings from the doctor, because what was presented to her was not congruent with the woman's previous birth experiences. Mary's insistence on the intervention of an enema enabled the woman to have a normal delivery, and prevented a caesarean section. There seemed to be a difference in knowledge and experience between the registrar and Mary. Mary was not worried about what the doctor thought about her repeating a VE after him, as her focus was on achieving the best outcome for the woman. She trusted her own knowledge and experience, acted accordingly, and the result was a "normal birth". In making her

decision, Mary managed both the situation as she saw it and the doctor, thus keeping open the opportunity for normal birth.

Like Mary, Bronwyn manages to prevent a forceps delivery by having the confidence to intervene:

I was doing charge and I was walking down the passage as a GP was phoning the registrar about a forceps for this woman. I walked into the room and took one look at the situation and realised it was ineffective pushing and that was the reason for the hold-up. I turned the woman into the left lateral, talked to her and said, "I'm actually going to want you to push for another quarter of an hour. Do you think you can do it? Do you want to do it?" And she said, "Yes," so I got her into position and coached her. By the time the GP came back into the room I had the head on the perineum and he was absolutely gob-smacked. He said, "How did you do that? We have been pushing for an hour and a half and haven't moved it!" The woman proceeded to have a normal delivery. The registrar arrived too late for the forceps and it was just so simple, but really effective for the woman and she was really thrilled. (Bronwyn).

It seems that the birthing room has a "certain space experience", and there is a "learned social character of space" (van Manen, 1990, p. 103) that should ensure privacy for the woman to allow birth to unfold. This space carries within it certain meanings and expectations, and may make some practitioners hesitate before entering the room. Bronwyn did not have to go into the room to find out what was going on. She could have accepted that the woman was not going to deliver normally. However, it seems that, for some reason, she was compelled to go in. This midwife has a philosophy of always trying to achieve normal birth outcomes. It could have been that she was in charge of the unit and wanted to be aware of what was going on, or she may have been simply following her intuition, and felt compelled to enter and find out what was going on.

Is it the role of the charge midwife to be the gatekeeper of maintaining "normal" births in the delivery suite? Is she watching out for intervention and endeavouring to prevent

it, thereby maintaining normal birth outcomes? A demonstration of confidence in midwifery practice is apparent here. If the midwife had not been confident in her own practice the outcome may have been very different.

Although the GP had been trying for an hour and a half, the midwife was able to make a significant difference. Is that because midwives are experienced in trying different positions? Is it because they are with women so often they know when a woman is not pushing effectively? Midwives appear to have a different clinical perspective from that of medical practitioners (Wagner, 1994). A further consideration is whether there was a more junior midwife present with the GP, and if so, why she had not made a difference. It seems possible that a different voice and fresh eyes can sometimes help to bring about a normal birth, when energy for both the woman and practitioner are waning.

A further example from Mary is her story of a woman who has had a previous caesarean section and needs syntocinon augmentation. Mary shares her frustration with a registrar:

So I put the syntocinon up and we had this particular registrar who is hovering to do a caesarean and he is in and out of the room every half-hour. "How is she getting on? How is she getting on?" "She is fine, she is doing OK, she is fine." Of course he was a new registrar at the same time so he wanted to do everything right, and he was quite worried about it and examined her and she hadn't progressed. I said to him, "Let us just put the syntocinon up a little bit more; just a couple more notches." It was on 8 mu. Most of the doctors will say, "Oh look we'll leave you to it because you are not going to push it like mad." So this guy was hovering around and I said, "Just let me go up two notches?" He said, "I'll have to ask my consultant." So I said, "OK, you ask your consultant."

Anyway the consultant came in and he said, "You want to put it up?" and I said, "Well you want to give her a trial of labour and we are not going to get anywhere with these contractions," He said, "OK, I'll leave it to you. You put it up. You know what you are doing." So, "Fine," I thought, "Take that little fellow [the registrar] with you and keep him!" (laughter). Anyway the

contractions started to come quite good and nice and solid and relaxing in between and it was beautiful and the next thing she was fully dilated. Gradually she pushed and pushed. So I rang the registrar and said, "Do you want to come and see this baby being born?" Well he couldn't believe it and she had a normal delivery, so that was good (Mary).

The relationships Mary has with the registrar and the consultant are obviously very different. She appears irritated by the nervousness of the new registrar, who restricts her authority. Her relationship with the consultant, however, is one of mutual respect, so he gives her the authority to do as she wishes, and she is able to achieve a normal birth for the woman.

When Mary calls the registrar to come and see the birth it is possible that she wants to teach him that she can be trusted, to keep birth normal. Mary's experience gives her an advantage over the doctor. The difference in relationship of the lived "other" seems apparent here, one that is restrictive with the registrar and one that is of mutual respect with the consultant (van Manen, 1990). Variations in doctor-midwife relationships can influence birth outcomes both positively and negatively, although it appears that the midwife will try to manage or influence doctors towards achieving her aim of a normal birth.

Mary is confident that with a bit more syntocinon the woman will achieve a normal delivery. She appears to be hindered by the new registrar who is very nervous. The registrar does not appear to trust Mary to make her own decision as regards the use of syntocinon. Therefore Mary convinces the registrar to speak to the consultant and she achieves her aim to leave it to her because she knows what she is doing. The relationship between the consultant and Mary appears to be a respectful one as she is then given the authority to do what she wants to do and she achieves a normal birth for this woman.

Mary calls the registrar to come and see the birth. Is this so that Mary can teach the doctor that she can be trusted and show him it was the right decision? It seems that Mary wants to show the registrar that the woman did and could have a normal birth.

Experience seems to be an influential factor here and the doctor being new in his role appears to be less experienced than Mary. This reveals as previous outlined, that variation in doctor/midwife relationships can influence birth outcomes positively and negatively. Although it appears that the midwife will try and manage or influence any doctor towards her way of thinking if she can to achieve her aim of a normal birth.

Bronwyn, like Mary, also seems to be affected by the doctor's decision-making. She shares her experience of a woman who has been sent to delivery suite for a caesarean section:

This woman was a previous normal delivery and she really wanted a normal delivery this time. She was a tall Indian lady and came up from clinic with a history of an APH [antepartum haemorrhage], an irritable uterus, query abruption, and an IUGR [Intrauterine growth restricted] baby. Anyway, I put her on the monitor and she had the most beautiful fetal heart trace and I took the history from the woman and decided that the APH was a 'show'. According to the woman, the size of her baby wasn't that much smaller - in fact was bigger than her last baby, and her contractions was early labour.

I said to the registrar, "Why are we doing an elective section on this woman?" She said, "Because the consultant in clinic said." I said, "I don't actually see any reason for this woman to have a caesarean section," and she said, "Well that's what I have been told to do." Luckily I knew the consultant on for delivery suite. I said to him, "Would you like to have a look at this lady because I don't believe she needs a caesarean and she doesn't want one." So he came in; he looked at the trace and he felt her abdomen and he said, "Well I don't really see any reason for a caesarean either but we may as well be prepared and then were ready, and if we need to section her we can." So the woman was happy and she had a normal delivery about 8 hours later.

It was just having the experience and confidence to question the doctors and to go higher than the registrar: to actually have the confidence to go to the consultant and say, "I really feel this is an unnecessary caesarean section." Her

baby was a reasonable size but it was not getting too wound up in the abnormal and saying, "Hang on a minute; she's had a show. She's in early labour." Whereas they [the medical staff] just thought "abnormal" from the time they saw her. I was quite pleased with that one and thought that was one caesarean I prevented (laughter) (Bronwyn).

What has reassured Bronwyn that everything is all right and normal? Is there such a good fetal heart tracing that Bronwyn feels that the woman could not possibly have aborted? Perhaps she has listened to the woman's description of what has happened to her with a different ear? Somehow, she is aware that the woman does not want a caesarean section, so she endeavours to keep the woman normal because everything seems normal to her.

Bronwyn stands up for the woman and herself, and questions the doctor's decision-making in clinic. Is this about re-thinking and questioning decisions if they do not feel right? Is it about being an advocate for the woman as long as you feel the baby and mother are not compromised? Is it that the doctors are so used to the abnormal that they have lost sight of the normal? Perhaps there was a semblance of abnormal. An entity may show itself, as something, which it is not, but may seem to be (Smythe, 2003). When the midwife looked at the whole picture she saw something different: the normal being made abnormal. Bronwyn will not be led down a path that she feels is inappropriate, and persuades the consultant on the delivery unit to review the woman again. It seems to me a bit like sheep following the leader and not questioning where they are going. A decision is made in clinic and everything follows on from that decision without questioning whether it is the right one. The doctors are just doing what they have been told to do "because the consultant in clinic said so". Bronwyn, however, has the courage to challenge and question what they have taken for granted, thereby influencing the outcome, and achieving normal labour.

People sometimes refer to others as "they", as defined by Heidegger meaning no specific person (King, 2001). "They" might judge us, and determine what we should or should not do, as Bronwyn indicates, "they [the medical staff] just thought 'abnormal' from the time they saw her". What "they" might think regarding the situation, their

decision making and clinical expectations of practice seems to influence decisions made about the care of women and, consequently, about normal birth. “Influencing the doctors” seems to depend on who is on duty in terms of the different registrars and consultants and the relationship they have with the midwife, as well as the response of the woman and what her expectations are in labour.

Working as a team

There are times when the doctors and midwives work very well together to keep birth normal. There is a trust and respect for each other’s skill and opinion, and they are a team. Sarah talks about a delivery where she felt it was positive:

There was a twin delivery recently. It was the woman’s first babies and IVF which in the particular setting was a challenge but also very, very positive because I got to deliver both the babies. We kept it very focused on her and her experience rather than turning it into a medicalised exercise in getting two babies, even though we had what could be termed as intervention. We did have an epidural, but we didn’t have an instrumental delivery at all. We ruptured the second twin’s membranes but we didn’t the first twin. We were able to keep her mobilised even though we were monitoring until she had the epidural. There was no flapping of paediatricians, no preoccupation with fetal distress, episiotomies, paper work or all that sort of thing. The consultant was at the other side of the room and physically not a presence in the delivery, which is very unusual and we kept things very normal. The woman wasn’t scared and was just very cruisey and very much just enjoying the experience which made it easier to make it fun and turn it into a celebration that it deserves to be (Sarah).

In Sarah’s view, keeping birth normal means ensuring that the interventions the woman has are fewer than they might have been. It appears that the doctors in this story were there if they were needed and stood back, only to intervene if necessary. Everyone worked well together because they kept the focus on the woman. What made the difference in this situation was that Sarah and the doctor were “in tune”. The emphasis was on working together and staying calm. It was, as Sarah says, “a celebration that it

deserves to be”. There seems to be a quiet confidence in all the practitioners that keeps birth normal for this woman.

How were they able to watch and wait? What enables some obstetricians to stand back and let birth unfold, while others are unable to trust in the process? The answer may lie found in the trusting relationship that the midwife and obstetrician have developed together, as well as the confidence and experience that is within each individual practitioner.

Sarah’s experience was a good one, because the doctors were supportive but kept a low profile. Sally shares an experience with a registrar about how their ability to share the decision-making enables a woman to have a normal birth:

I was acting charge midwife of delivery suite on night shift. The LMC was an independent midwife. A Polynesian multiparous woman, gravida four, para three was 5cms dilated and was contracting very well. The midwife had done an ARM and there was thin meconium liquor and on the CTG she had variable decelerations. An hour later the registrar decided to do a pH and it was normal so we carried on. I just kept in mind to keep an eye on that room.

About an hour later they did another pH but the sample clotted. The registrar phoned her consultant, who was at home. The consultant gave her the advice, “Look if you can’t get a sample and if you are significantly worried about the trace take her up and do a caesarean section.” The registrar came to me and wanted my advice. She was a junior registrar and had been with us for a few months and just wanted advice from someone who had worked more in delivery suite and seen more fetal heart traces than she had. So I went down with her and I had a look and the fetal heart tracing had deteriorated from the first pH² sample but there was still reassuring signs. I gave my opinion that she could actually watch and wait instead of doing something immediately. She said, “Yes

² The pH is used as a measure of whether the body is maintaining a normal acid-base balance and indicates if the fetus is in a good condition or not.

I think that we could wait a bit longer before taking this lady up for a caesarean that possibly could be unnecessary.”

We did watch and wait and I expressed my feelings that I thought she would deliver within the hour and in fact she did. She had a normal vaginal delivery. I was present and the baby came out crying. It was in good condition. I think what made a difference was the relationship between the doctor and myself. We respected each other’s abilities and she could come to me and I could go to her and she went with my advice and we had a normal birth (Sally).

Sally appears to have a good relationship with the registrar and is recognised and respected for her experience. By sharing the decision-making between the practitioners they enable the woman to have a normal birth. The practitioners are working together to ensure that there is a good outcome for the woman and her baby. Sally does not interfere, but she is aware of the need to just keep an eye on what is happening in the room, to be supportive to the LMC, and assist if she is needed. Because the consultant is at home s/he can only give advice by phone that is safe for the registrar, as s/he cannot see the fetal heart tracing. It is teamwork and sharing the clinical decision making that ultimately avoids an unnecessary caesarean section.

Bronwyn also shares her experience of working with the doctors as a team. She looked after a GP’s client, an Asian lady who was a Gravida two, Para three:

We knew it was a big baby and it was OP. She had failed to progress and was stuck at 9cm. The consultant on was very experienced and so was the registrar and they had come from the hospital where I used to work. So we were all really confident with one another’s abilities and the consultant did a VE and manually rotated the baby to nearly OA and in doing so also managed to get her to fully dilated. Then the head was still really high but he said to me, “Now get her pushing,” and in the meantime they would go and organise to go around to caesar theatre for query a forceps or a section.

I talked to the woman and said, “You know we really have to push hard to get this baby down. We have a time limit and we have to beat the doctors.” I suppose it was partly confidence in me and just listening and we got pushing and she did really, really well and pushed really hard. By the time the doctors came back we had got it far enough down that we didn’t have to go to theatre for a trial of forceps. Then just with a bit more pushing and their ability to just wait we had a normal delivery in the room.

I don’t think any other consultant would have rotated that baby manually. The consultant realised that the delay in dilation was just related to the OP and he was confident in his ability that because it was OP we didn’t get to fully dilated and he would rotate it manually. She got to fully and he was confident that we would get it down without shoulder dystocia. I think the three of us worked well as a team. I think the midwife had to have the ability to have the confidence that it would be a normal delivery and portray that to the woman. The woman then had the confidence that she could do it and we got a nice normal delivery and it was good (Bronwyn).

Bronwyn recalls, almost fondly, the relationship she has with these doctors. They all seem familiar with each other because they have worked together. They obviously have a trust in each other and a respect for each other’s skills. The consultant is praised for his ability to keep birth normal, because he is not worried about what could go wrong in terms of shoulder dystocia. This seems possible because of the doctor’s experience. Even though he does manually rotate the baby, which could be considered an intervention, it enables the woman’s labour to progress normally afterwards. There still seems to be a race against time before the doctors will intervene. However, there is the ability for the doctors to wait and allow more time before they do. Bronwyn then talks about the giving of confidence to the woman, and encouraging and supporting her to achieve a normal birth. They all appear to want a normal delivery for this woman and do what they can together to keep birth normal.

Kay, like Bronwyn, talks about a mutual respect with the doctors in the hospital where she works. However, she observes that when the doctors are new it takes time to get used to what is expected of them in her particular unit:

There is definitely with the senior midwives, registrars and consultants a mutual respect and recognition of the other's skills and way of practising. When you have a new lot of registrars come, they always stay close by in delivery suite until they get to know who's who and how we work. Once they have been there a while you don't actually see them as often as when they were getting to grips with how things work. Obviously in a lot of other units where they have been they have directed the whole labour and the midwives have sort of been handmaidens I suppose, whereas that certainly doesn't happen in the hospital where I work. Even some of the high-risk women we organise and manage the labour care and delivery and unless there is cause for concern you may not see a registrar.

I think we do work well together as a team: it's not them and us. I think that is why we have such good normal birth outcomes and they recognise normal birth as the midwives' area of expertise. Sometimes if they are doing a bit of a round around delivery suite some of them might say, "Oh look we don't need to go in there. She's having a normal labour." But I don't feel threatened if a doctor knocks on the door and wants to come in; it's fine (Kay).

Kay highlights the different cultures of medically managed birth in other facilities, and remarks on the tensions this can cause when doctors move to midwifery-led care. Some may have difficulty in learning to trust the midwives, and there may be a period of transition as this trust grows. At the particular unit where Kay works, a unique relationship seems to have developed between the medical and midwifery practitioners. The doctors appear to acknowledge that if a woman is labouring normally it is the midwives' domain and there is midwifery-led care. A relationship of trust and mutual respect exists, and Kay feels that this influences normal birth outcomes. It appears that midwifery-led care within a secondary care setting does help to keep birth normal. There is an expectation that the women may not see a doctor unless there is a problem,

and this also helps to keep birth normal. Kay identifies that at other hospitals the doctors manage labour, and the midwives do not appear to be practising so autonomously. She indicates that there needs to be a culture that nurtures the relationship between midwives and doctors to form a trust and mutual respect in order to keep birth normal.

Summary

The practice of “hiding women” from intervention reveals the conflicting philosophies between midwifery and medical personnel. This does not mean not intervening at all, but is about the appropriate timing of intervention: deciding when a woman is in established labour, determining appropriate progress in labour, and admitting her to delivery suite at the right time. These are the occasions when, from the participants’ perspectives, the women sometimes need to be “hidden”, in order to prevent unnecessary intervention, and so keep birth normal. The participants are still very aware of the possible consequences for the registrar and consultant but have developed confidence and experience within their own clinical decision making.

“Midwives’ caughtness with doctors’ decisions” reveals the tension between the decisions made by medical personnel and the midwife’s belief that there could have been alternative decisions that may have influenced the outcome towards a more normal birth or a better experience for the woman. The participants indicate a powerlessness when the decisions have already been made, prior to their caring for the woman, and feel that by the time they become involved it is too late to do a lot of things they would have done to assist a woman towards a normal birth. They suggest there is a need for justification for any intervention, and for the timing of an intervention, thus placing a woman in a more favourable position for labour in the first place.

“Influencing the doctors” is about trying to manage or influence any doctor towards the midwife’s way of thinking so she can achieve her aim of a normal birth. This is because of the authority of the doctors over decision making in labour. It also depends on who is on duty, the experience of the medical practitioner, the anxiety or trust created between midwife and registrar or consultant, and the response of the woman and

her expectations. The midwife can try, even when the odds seem against her, and this ability seems to come from her experience and confidence in practice.

“Working as a team” indicates mutual respect and trust for each other’s abilities, and an overall philosophical commitment to the promotion of normal birth. It requires an institutional culture of midwifery-led care, and respect for experience in clinical midwifery practice. This requires the obstetricians’ ability to stand back and allow more time for birth to unfold, only intervening if necessary. The participants in this study identified that this was the best way to keep birth normal.

CHAPTER SEVEN

Discussion and Conclusion

Introduction

In order to come to some deeper understanding of what it means to keep birth normal for a core or hospital midwife in a secondary care setting the experiences of eight midwife participants have been explored. In this last chapter I will discuss the themes that have emerged from my analysis. This qualitative study also incorporates my own midwifery experience and knowledge, as well as an exploration of related literature and historical influences. Implications for midwifery practice, education and research will be addressed and limitations of this study will also be considered.

While this study upholds the notion of keeping birth normal it is important to note that at times women and babies do require medical intervention. This study in no way negates the fact that medical expertise is required to maintain the safety of some women and babies (World Health Organisation, 1996).

The research question and aims

The research question is: “What are midwives’ experiences of keeping birth normal within a secondary care setting?” The midwives shared their experiences in relation to normal birth within the hospital facility where they worked. They also shared some of the influences related to their practice when trying to keep birth normal within the secondary or tertiary setting.

The research aims and how they have been addressed are as follows:

- To identify the midwifery skills that are used to achieve normal birth outcomes.

In Chapters Four, Five, and Six, the participants in this study describe many skills that they as midwives use to achieve normal birth. The participants are conscious of the pervasiveness of technology within a secondary and tertiary facility. Judging if and

when to use this technology, and judging when intervention may be needed and when it is not, is a necessary skill. Therefore, intervention is carefully considered.

The participants in this study echoed Leap's (2000) findings. Leap identified that pain in labour is central to women's childbirth experience and that there are two different approaches to this pain: "working with women and their pain", or offering pain relief (p.50). Working with women and their pain is an integral part of midwifery practice, where the midwife helps a woman to cope with the pain of labour, rather than going straight for pain relief options. This was identified by the participants in this study as an important midwifery skill in keeping birth normal. There are times however, when there is a need for pain relief. In Leap's (2000) study this was usually associated with abnormal labour.

The study participants stated that women themselves strongly indicated their own preferences for pain relief and had different expectations around pain in labour. The participants would try to judiciously influence a woman, at times, to cope through the pain of labour without pain relief in order to keep birth normal, but ultimately the women decided what they wanted. The participants were very much aware of epidurals as a pain relief option within their facility and how this anaesthetic technology can influence birth, as outlined in Chapter Four. They identified that they needed to skillfully manage an epidural to achieve normal birth outcomes. In other words, even in the midst of an intervention assisted labour there are still efforts to safeguard normality.

Patience, in terms of the required time for women to birth normally, is also an important part of this phenomenon. Building a positive relationship with women and giving them the confidence to birth normally is also central to midwives practice.

In summary, the carefully considered judgement and technical expertise or skills identified for achieving normal birth outcomes are: judicious use of technology and interventions, working with women's pain, skillfully managing epidural analgesia, having patience, giving women time, and finally, instilling confidence in women to birth normally.

- To reveal the midwifery knowledge and experience that enables normal birth to occur in this setting.

Midwives gain midwifery knowledge through the experiences lived, in everyday practice. The participants identified that learning from other midwives and passing on midwifery knowledge enables them to acquire the confidence to keep birth normal. They also revealed that their ability to keep birth normal comes from a philosophy or belief in normal birth. They develop “little rules of thumb” or tricks of the trade, which they can draw upon to keep birth normal.

Alongside the “little rules of thumb”, knowing “the right time” also seems to be an important part of midwifery wisdom that is gained through experience. Midwives have developed knowledge and expertise in assessing when intervention is appropriate or not, and in deciding when to “step back” or when to “step in”. There is perseverance, patience and determination to keep trying to achieve a normal birth outcome for women even when the odds seem stacked against it.

- To examine influences upon midwifery practice and normal birth.

The participants identified three main influences upon midwifery practice. In the first place, the participants themselves influence midwifery practice by sharing their skills and experiences with junior midwives, and may choose to “step back or step in” to influence midwifery practice and keep birth normal. The second influence is the attitude of women themselves, which can have a strong positive or negative impact upon normal birth. The influence of doctors on birth outcomes, and the way that the participants influence doctors in order to keep birth normal, are recognised as the third key influencing factor.

The themes of this study

Three main themes emerged from the analysis. The first theme is “Being a midwife ‘is’ keeping birth normal”, the second is “Stepping back and stepping in”, and the final theme is “Interacting with the doctors”. These will now be discussed further.

Dasein: Being a midwife “is” keeping birth normal

The notion of what it means to keep birth normal is not something that can be kept safe in books. It must be lived out in embodied practice. “Being a midwife” is, in its very essence, the process of keeping birth normal; it is about assisting a woman towards a normal birth outcome. It is the everyday living, which includes seeing normal births unfold, that creates a knowing about normal birth. The participants have developed a belief in normal birth, which underlies their commitment to keeping birth normal. This belief in normal birth is an integral part of who they are as midwives.

In this study it appears that the midwives are always in “Dasein” or being, as identified by Heidegger: always living hermeneutically (interpretively), and finding significance in their world amidst their practical affairs (King, 2001). In their average everydayness of being a midwife they have an underlying philosophy of believing in normal birth. However, they are not in the world alone. They are always relating to “others”, even in their absence. Although they may have a belief in keeping birth normal they are influenced by “others” in the environment in which they work. The midwives in this study, however, reveal that they have developed a sense of what normal birth means within the “self”.

There are many different notions of what normal birth is, as outlined in Chapters One, Two and Four. For the midwives in this study “normal birth” is a notion or perception within the “self”. This notion of “self” Heidegger referred to as the “various modes and ways of the self” that are significant to our existence (Gelvin, 1970, p.64). What midwives will accept as “normal” and others will not, is dependent on many variables that have shaped their existence. Therefore, the notion of what normal birth is for the “self” can change over time, and always exists within the context of philosophy, culture, social background, professional history and development (Downe, 2001; Kitzinger, 2000; Wolf, 2001). The participants emphasised the need to see normal birth. The importance of learning this through lived experience and seeing birth unfold is seen as essential to keeping birth normal. If birth is always seen as requiring intervention, then it can become much more difficult for a midwife to imagine, or believe, that the birth process can be better without intervention.

Even though the study participants are constantly exposed to intervention within their secondary care setting, they still believe that preventing unnecessary intervention is like “a battle that needs to be won”. In other words, they are aware of the effects of intervention upon normal birth, and endeavour to prevent what they believe is not appropriate. The philosophy in The College of Midwives’ Guidelines for Practice (2002) stated that “midwifery care enhances and protects the normal process of childbirth” (p. 3). The participants’ belief in normal birth means that they see what is deemed as inappropriate intervention as something to “battle” against in order to protect the normal birth process.

The participants learned their philosophy of normal birth from more experienced midwives who orchestrated normal birth experiences and helped them to see and believe in the normal. A midwife’s belief in normal birth underlies her confidence in the process. She then passes on this confidence to women and junior midwives. The participants in this study recognise that if they are unable to orchestrate an experience that helps junior midwives to develop a belief in normal birth then this could influence these midwives’ confidence in normal birth. Vague (2003), in her research on how midwives work with the woman and her pain in labour, showed how strongly a midwife’s belief in “normality” influenced the woman’s willingness to experience birth without intervention.

Learning through sharing knowledge: developing a “little rule of thumb”

The participant midwives recognise that they learn their skills from other midwives. These skills are passed from midwife to midwife. The midwives in this study feel that sharing midwifery stories and dilemmas with each other helps them to process what has happened to them within the setting. They support each other to learn the art of midwifery, to keep a midwifery focus, influence outcomes, and reflect on their practice. The study participants reveal that in the secondary care setting they have developed perseverance, patience, and a determination that enables them to achieve a normal birth outcome. They have learnt their wisdom from other midwives along the way:

When I was a new graduate midwife, one of the experienced midwives said to me, “Never rupture a multip’s membranes if she is less than 6cm”, because often you get these ones that are 4-5cm that aren’t really in labour and then you end up with that cascade of events or intervention. That’s my little rule of thumb...(Kay)

It is not easy, but they keep trying, woman by woman, day by day to reach their goal of a normal birth.

Participants in this study indicated a pattern of first consulting with midwifery colleagues as opposed to medical staff. The custom of midwives asking midwives within the secondary care environment, rather than automatically deferring to doctors, is an essential element that the participants have identified in helping to keep birth normal. If they discuss midwifery issues with other experienced midwives the art of midwifery is passed on. Crabtree (2000) found that the medical model “is always there and taken as the ‘right’ way to ‘do’ birth unless it is actively contended.” (p. iv). If the midwives discuss what they should do directly with a doctor they are going to automatically get a medical response.

The participants in the study also identified that the woman’s birth experience was just as important as the outcome of a “normal birth”. The intrapartum experience is recognised as being integral to the woman’s satisfaction. Therefore, at times the participants assisted a woman to have an epidural even though personally they felt she could get through without one. Beech (2002) identified that giving women true choice does, at times, mean going against what the midwife believes is appropriate. Beech (2002a) also suggested that before midwives address issues around women-centred care, we need to define more clearly “what constitutes a normal birth” (p. 2). Some would argue that the culture of the institution where women choose to birth “constitutes normality” in such a way that makes them more accepting of intervention (Crabtree, 2002; Donley, 1986; Downe, 1998; Kirkham, 2000; Kitzinger, 2000; Page, 2000; Parratt & Fahy, 2004; Young, 2003). Others argue that even within such institutions, the level of midwives’ professional autonomy and partnership between woman and midwife can ensure a holistically safe place for “normal birth” to occur (Parrot and

Fahy, 2004). The midwives in this study show that it is possible to assist a woman to have an experience that she feels happy with, within the secondary care environment, and also have a “normal birth”.

Stepping back or stepping in

The notion of “being-with” others is fundamental to humanity and the structure of who we are, as “man (sic) exists essentially for the sake of others” (Heidegger, 1927/1962). Being-with others can be in an “owned” or “disowned” way, which is illustrated in the “care-for” others as explained previously. (It is important to note that the use of the word “care” in Heidegger’s writing does not necessarily imply warmth and concern. It is more a sense of responsiveness to other). Heidegger highlighted our human tendency to “jump in” or leap in for another and take care of the other, or take care of things for the other. However, “stepping in” or leaping in means that the other is displaced, when they perhaps could have taken care of things for themselves. This can result in dependence on the other, or a dominance of the other, which may go unnoticed in everyday living and being with others, especially when considering the different environments in which we work and live. The other way of caring for others is one that “jumps ahead” or leaps ahead - not to take the care away but to “give it back to her properly as her own” (King, 1964, p. 106).

“Stepping back or stepping in” means judging when intervention might be appropriate or inappropriate. To step “in” or not is always in question and open to possibilities. The distance that is felt, as outlined by van Manen (1990) in relation to these two words, makes the midwives think about their actions. The midwives identify that it is important to judge when to step in and do something that is considered to be minor, such as “a bit of Pethidine” as opposed to an epidural or “an ARM” to augment labour which possibly may prevent a caesarean section or ventouse delivery.

The midwife might step back and encourage the more junior midwife or student to develop her own level of autonomy and try not to intervene, but sometimes it might be necessary to show the more junior midwife the way to achieving a normal birth by stepping in.

If every thing is normal then I step back a bit ... not to jump in too quickly... Unless I feel there really is a need to step in and take charge if I think there is a problem (Sally).

Judging when to step in or step back is part of giving confidence to “others” and being confident in practice. The midwife might also “step back” or “step in” when relating to the doctor. They might encourage doctors to step back and allow labour to establish, or give more time for a normal birth to occur. The midwife might also step in and seek to influence the doctor by reviewing decisions that have been made by other medical practitioners. This is discussed further in the section: “Interacting with the doctors”.

Women-Led

The participants in this study reveal that core midwifery care, although fragmented, is still woman-centred and woman-led. The midwives try to work with what the woman wants and this may have a positive or a negative effect on whether the midwives are able, or not, to keep birth normal. Working with women and helping them to have a birth experience that is acceptable to them means that sometimes midwives go along with what the women want, and the women themselves will keep birth normal.

We just have to give it some time...she was very positive that she didn't want a caesarean...she was quite determined (Gabrielle).

Sometimes the women do not want to listen to the midwife, and insist on having an intervention. This can possibly affect normal birth outcomes.

She was so grateful to me for getting her this epidural although deep down I knew she didn't need it. She just said that she felt I had listened to her and had taken into account her choice (Sally).

The midwife is sometimes restricted in keeping birth normal because of the “other”: in this case, the women themselves.

The midwife is not only affected by the woman's expectations of labour, but also by those of her support people, who can directly influence the woman:

Her partner was getting very upset seeing her in pain and he couldn't handle that (Maggie).

The decisions women make in labour may be because of the effect of their support people. If they are not coping the woman might find it difficult to cope with what is happening. If they are strong and supportive she will feel stronger and able to cope. The lived "other" - the support people present - may have an effect on the normal birth process for women and midwives. The presence of support people in labour, however, usually does have a positive effect on birth outcomes (Enkin et al., 2000).

Interacting with the doctors

Despite the medical model dominating the secondary care environment the midwife within her "self" and "being" is always trying to influence a normal birth outcome for women as part of her inner belief or philosophy. The philosophical stance of midwives is that birth is intrinsically normal (New Zealand College of Midwives, 2002; Rosser & Anderson, 1998). Midwives who work within the realms of medicine can relinquish this philosophical stance and therefore in "being a midwife" they may also be aware, or even unaware, of "not-being" a midwife in certain ways (Gelvin, 1970, p.65). One participant in this study illustrates this "not-being" when she says that a forceps or a ventouse could constitute a normal birth for some women. Being in the world, for the midwives in this study, is being in the world with conflicting possibilities. The midwives are aware of the possibilities of a normal birth being defined or constituted by the midwifery or medical models of care. These conflicting possibilities mean that a midwife in a secondary care setting has to work within either model of care. Claiming that a forceps or a ventouse is normal for some women, because that is what is deemed as clinically appropriate for the woman to give birth, indicates the "normalisation" of medical intervention.

The medical interventions of a forceps or ventouse is not considered to be part of the midwifery model of care or "normal" birth, as outlined in Chapters Two and Four.

However, the dilemma comes when women are made to feel that they have had an “abnormal” birth and midwives do not wish to offend women with the suggestion they have failed because they required medical intervention (Duff, 2002; Phipps, 2002). While the midwife is aware of what constitutes normal birth for her “self”, the “being or not being a midwife” is seen primarily in relation to the quality of a woman’s birth experience rather than the actual having of a normal birth.

For some midwives the battle becomes too difficult and their emotional wellbeing might be maintained by accepting that they have no control. They become entrenched within the medical model or culture of the institution in which they work (Downe, 2001; Kirkham, 2000). Stafford (2001) suggested that this may cause some midwives to become disgruntled and leave the profession. She stated, “When nobody seems to trust your abilities and experience it is easy to lose heart” (p. 46). The participants in this study indicate that they may be forced to “not be a midwife” in their own “self” while caring for a woman when decisions about the woman’s care during the birth process is taken out of their hands. This happens, for example, when a medical practitioner is the LMC and the midwife is providing supportive midwifery care only, or when the decisions regarding a woman’s care have already been made before the woman is in the midwife’s care.

In Chapter One, I identified my presuppositions about how I thought midwives, women and doctors would influence midwifery practice. I was surprised, however, by the way in which the participants themselves would try to strongly influence not only their own practice towards a normal birth outcome but also the practice of “others”. van Manen (1990) referred to “self” and “other” as being fundamental to human relations (p. 89). The main skill of working within this environment is achieved through interaction or “being with” others, and depending on who those others are, different strategies or skills will be required. “Being with others”, is about the sharing of interpersonal space and experiences. Smythe (2002) identified that as an individual or “self” we cannot be separated from the context within which we are situated. If one is not happy it is because of someone or something, “the Dasein or being-in-the-world cannot be avoided. It is as it is. It is a world shared by others: I can only understand self in

relation to how others affect my notions of self” (Smythe, 2002, p.173). The midwife is who she is in relation to who the doctor is and who the woman is.

When referring to “others” we might refer to “they”, being no one specifically. “They” might judge us, and determine what we should or should not do. The “they” tends to be hidden. We do not necessarily recognise the power of their influence. The participants might refer to “they” when they think their clinical judgement may be called into question: for example, the expectation that a grand-multiparous woman will have a leur inserted if she is in labour or has had a previous caesarean section, is what “they” might think is safe practice.

It is important to distinguish between “they” and “others” because when referring to “they” we may close down possibilities, whereas relating to “others” creates a knowing and a trust that helps us with being open to possibilities (Heidegger, 1927/1962). The midwives in this study only occasionally referred to what “they” might think in regard to the situation, their decision making, and clinical expectations of practice. The midwives usually referred to “others” who influenced them in keeping birth normal. It depended on who was on duty in terms of the different registrars and consultants, and the relationship they had with the midwife. The participants were all fairly experienced midwives, and this raises the question whether that is why the midwives were not worried about what “they” thought. It is possible that less experienced midwives might worry or be affected more by what “they” think. The response of the woman and what her expectations are in labour can also affect what “others” or “they” might think.

The following section discusses ways that the midwife relates to the doctor within a secondary care setting.

Hiding the women from intervention

The midwife will try and protect the woman from medical intervention, sometimes almost “hiding” her from doctors by perhaps telling her to go for a walk, or trying to keep the doctors out of the room. Such hiding of women from intervention is a strategy used to deal with conflicting philosophies between medical and midwifery personnel. The participants were not against intervening at all, but they believed in the appropriate

timing of intervention. They would “hide” women who they felt were going to receive intervention not yet needed. They were still aware of the possible consequences upon the doctors if anything should go wrong, but did not want to compromise the care of the woman either. These midwives were very confident in their own practice and clinical judgement.

Midwives’ ‘caughtness’ with doctor decisions

The medical practitioner in the secondary care environment has a major influence over the midwife when it comes to keeping birth normal. The midwife is unable to keep birth normal if the decision making is taken out of her hands and she feels she has no control over the situation.

*All the decision making process and all the power was held by the doctors
(Sarah).*

Medical decisions, such as inducing labour without a valid reason or starting syntocinon when a woman is not favourably in labour, are identified by the midwives as compromising normal birth outcomes. The lack of ability to influence the situation towards a normal birth was extremely distressing for the participants. A normal birth outcome was compromised and was no longer within the midwives’ hands. A specific example of a midwife’s frustration was when an obstetrician offered a woman an epidural at one centimetre, and then after a short labour suggested a caesarean section. Midwives in this study described such examples as against their principles and belief of keeping birth normal. This calls into question the information given by health professionals to women throughout the process, and what constitutes informed choice and consent. The participants identified that at times women were not adequately consulted regarding decisions that were made about their care, and were thus not fully aware of the consequences of these decisions. The participants sometimes felt discouraged by the medical decisions and the resulting outcomes. At times, however, the participants did “step in” and give a more “balanced” view of the information that the women had already received.

Influencing the doctors

Participants in this study have the confidence to manage the doctor by suggesting strongly what they would like to do, thereby influencing the doctor's decision-making.

He [the consultant] said, "Ok I'll leave it to you. You put it up [Syntocinon]; you know what you are doing." So, "Fine," I thought. "Take that little fellow [the registrar] with you and keep him." (laughter) (Mary).

The participants will attempt to influence the registrar towards their way of thinking, and if they cannot influence that doctor they may go higher to the consultant in order to achieve a normal birth outcome for a woman. How they influence the doctors depends on who is on duty at the time: who the registrar and consultant are, and the relationship they have with them. Past experience of different medical practitioners will influence the midwife's approach. The midwife who has built up a relationship with the woman she is caring for is also influenced by the woman and her expectations of the doctors in each situation. The participants in this study identify that they will try, even when the odds are against a normal birth, to influence the outcome, and this includes managing medical staff. This comes from their almost passionate belief in normal birth and their experience and confidence in their own practice. This managing or influencing of doctors is generally done in a very diplomatic and sometimes subtle manner. It is important to note that influencing doctors and working as a team might occur simultaneously.

Working as a team

The participants appreciate and enjoy working with the doctor as a team: sharing mutual respect for the decision making of both parties, and working together to afford a normal birth for a woman.

I think what made a difference was the relationship between the doctor and myself. (Sally).

I think we do work well together as a team. It's not them and us...they recognise normal birth as the midwives' area of expertise (Kay).

The participants indicate that as part of team work there needs to be a mutual respect and trust in each other's abilities and an overall philosophical commitment to the promotion of normal birth. This appears to be achieved with midwifery-led care and when there is a respect for experience in clinical midwifery practice within a secondary care setting. Medical personnel do have the ability to stand back and allow birth to unfold and only intervene if necessary. This was identified as the ideal situation for promoting normal birth.

Participants also shared experiences of “re-educating” the medical staff who have worked in other secondary or tertiary settings and have been entrenched in a more medical culture.

When you have a new lot of registrars come, they always stay close by in delivery suite until they get to know who's who and how we work. Once they have been there a while you don't actually see them as often... Obviously in a lot of other units... they have directed the whole labour and the midwives have sort of been handmaidens... that certainly doesn't happen in the hospital where I work (Kay).

The participants indicated that they had a period of transition with new medical staff who were not used to the midwifery-led care within the hospital facility. They identified that it is not easy to maintain this culture, but they enjoy the trust and mutual respect that develops.

Living Time

For the participants in this study the significance of “lived time” is central to keeping birth normal. Time as it is lived slows down or speeds up depending on what is happening to the midwife in that particular moment: time to allow birth to unfold without intervention; time to start intervention if appropriate; time for a normal birth to take place. The reduction in the length of time for labour, through historical changes, has meant that expectations about how long normal birth takes in institutions is closely determined by clock time, with established guidelines that are expected to be achieved.

If time challenges are not met, intervention is ordered. The notion that “normal” does not necessarily mean following a regimented pattern has been lost under the dominance of an objective, measurable, scientific mindset of medicine. The midwives in this study looked for ways of protecting labour from the demands of the clock.

Being bodily in the world

There is an embodied knowing that the participants identify in their everyday practice: “being bodily in the world” (van Manen, 1990), in the setting that you are in. The participants in this study bodily experienced the satisfaction of influencing normal birth outcomes, and equally the frustration of the inability to make changes. The participants reflected on how their body speaks to them. For example, passion is felt, leading to the courage to question the decisions made by medical practitioners; frustration with the outcomes of a previous birth is felt, and goes on to influence practice in the next birth; respect is felt for the woman who says “no”. These are all embodied feelings. The participants also express feelings of elation, joy, and satisfaction when they experience working together with the woman to achieve the success of a normal birth.

Limitations of the study

- This qualitative study drew analysis from only eight core midwives from within the greater Auckland region. Therefore the study is not generalisable to all midwives.
- Midwives from different cultural backgrounds are not represented. Maori, Pacifica, or Asian midwives may find different challenges within the secondary care environment because they may not be used to different technologies and protocols within particular institutions. Their different cultural customs and traditions may not be recognized, but it was not possible to fully explore the effect of the secondary care environment upon their cultural practices within the constraints of this study.
- At the beginning of this study I outlined my own presuppositions in relation to the topic. My own experience of working in a delivery suite that is mainly midwifery-led may have influenced the interpretation of the data and research process. I recognise that many secondary and tertiary environments are more medical in their

culture than others. The Ministry of Health (2004) recently released their report on maternity care for 2002, showing that caesarean section and instrumental delivery rates vary widely between different hospitals. Higher medical interventions such as caesarean section and instrumental delivery rates within a hospital environment indicate an increased medicalised culture within that facility. The caesarean rate for the unit I work in was 15.9%, compared to rates of more than 28% in other facilities (p.79).

Implications for practice

The findings of this study show ways in which midwives keep birth normal, and this may be of interest to other midwives working within different secondary or tertiary care contexts. It may also provide some insights into the complexities of working within the secondary care setting and keeping birth normal.

I wish to emphasise the following points:

- Wise and experienced midwives have a legacy of knowledge that is most effectively passed on through working together, watching one another, and talking about their experiences.
- Junior midwives need the opportunity to work with experienced colleagues, both watching and being watched.
- Experienced midwives need to be available for consultation. This process should be formalised within the Ministry of Health (2002) section 88 maternity notice agreement and include consultation with junior midwives, medical colleagues and independent midwives.
- A culture that values normal birth grows when experienced midwives confidently demonstrate sound clinical judgement that results in safe outcomes.

- Opportunities need to be made for practising midwives to attend conferences and workshops, and be involved in postgraduate education. These are valuable forums for collectively safeguarding, examining and reconfirming the belief in normal birth.

Midwives and medical colleagues

This study revealed a degree of tension and mistrust between midwifery and medical colleagues. On the other hand, some midwives talked of very effective relationships. The key points learnt from their insights are:

- Efforts need to be made to open constructive dialogue between midwives and their medical colleagues towards understanding each other's beliefs and values regarding normal birth.
- Midwives and doctors who have achieved strong working relationships that both safeguard normal birth and initiate prompt intervention when required need to be showcased.
- Midwives and doctors need to develop a flexibility towards each other's care for women and accept that there may be different ways of achieving the best outcome, which is a healthy mother and baby and an experience that is acceptable to women.
- Consideration by midwives and doctors of how to keep interventions in labour to a minimum is required in order to keep birth normal. Judging when intervention may be required and appropriate, as well as acquiring this judgment or ability, also needs to be explored.

Implications for education

The midwives in this study, although working within a secondary care environment recognise the importance of seeing birth without intervention to develop a belief in keeping birth normal. Some educational implications, therefore, are the following:

- Students need the opportunity to work with midwives who have the experience and fundamental belief about keeping birth normal, in order to gain confidence in the normal, and also to learn when intervention might be appropriate.
- Student midwives need a range of experiences that encourage normal birth; for example, in primary care units or home births, but this needs to be balanced with secondary care experience.
- Students need to learn those “tricks of the trade” and “little rules of thumb” that have been developed by experienced midwives and are an important element in nurturing the next generation. At the same time, they need to explore the research evidence, so that they learn to examine the “truth” of these rules of thumb.
- Students and educators need to be aware of the importance of effective communication skills to allow them to constructively work through the tensions of practice situations, and to give them confidence in “speaking up” to keep birth normal.
- Students need to learn the art of midwifery from other midwives, so that their knowledge and wisdom is passed on through the sharing of stories and experiences.

Implications for research

This study identifies a need to further explore the philosophy and beliefs of midwives to share with others. It highlights some important considerations:

- Researching and sharing from the vast reservoir of midwives’ clinical practice experience needs to be documented, to pass on the art of midwifery.
- Midwives’ “little rules of thumb” and tricks of the trade need to be documented so that their evidence base might be explored. This seems especially necessary with regard to the practice of non-intervention, or smaller interventions to prevent the bigger ones.

- Attention should be given to the question of whether it may be in low-risk women's best interests to keep them out of secondary and tertiary units. This is, of course, a complex question, as it raises the issue of women's choice, especially in relation to the availability of epidurals, which are so prevalent in mainstream society today.
- Sociological and cultural factors influencing women's choices in childbirth need to be researched. This is with reference both to the birthing venue chosen, and the obstetric medical interventions expected by women.
- Further study is needed regarding the effect of the birth partner, or other support persons who may be present during the labour, because their ability – or lack of it - to cope with pain can influence normal birth outcomes.
- Research into the actual number of interventions women receive in childbirth, and the reasons for these, would provide valuable information that may help midwives and medical practitioners to reflect on their practice, and perhaps reduce the number of these interventions.
- Exploring and documenting different cultural beliefs, especially those of the Maori and Pacifica population, who have a less interventionist approach, may inspire others to keep birth normal.
- Research into the beliefs and views that doctors and obstetricians hold about normal birth would be invaluable in helping doctors and midwives work together more effectively.

This last point raises many questions for me. How do doctors come to know normal birth? How is it that some doctors have the ability to keep birth normal and trust the process? It does not seem good enough to say that doctors deal with the abnormal and midwives with the normal. Many women are having their babies within the secondary care environment, and although they may be low-risk, they are in contact with, and

influenced by medical practitioners. Until the issues around doctors and normal birth are explored there will continue to be increased intervention within this environment. How do we overcome these professional barriers? It is essential that the divergence of views between the medical and midwifery models come to some reconciliation, so that each may trust in the other's skills in the promotion of normal birth and provide the best possible environment for this to take place.

Conclusion

The midwives pointed out that they learned their midwifery skills, beliefs, and knowledge from being with women and seeing normal birth and from other midwives who encouraged them to keep birth normal. Skills which may have been learnt in home birth and other settings are passed on, and safeguarded even within the high-tech secondary care environment. A strong midwifery philosophy of belief in normal birth does exist in these core midwives who work within a secondary care setting. Neither midwifery philosophy nor the professional responsibility of being an autonomous midwife needs to be compromised by working in a secondary maternity facility. However, the culture of each secondary care environment can affect how the midwives fulfil their role, in some cases making practice a daily battle for keeping birth normal.

Midwifery-led care within a secondary care setting works best when there is a team approach to birth. The interrelationship between doctors and midwives needs to be one that is based on professional respect for each other's skills and judgements. A culture of normal birth is what needs to be nurtured, but it is not easy. It is hard work. If both midwives and doctors share a belief in the need to safeguard normal birth, and at the same time are watchful for what is no longer safe, then relationships are built on mutual trust that gives confidence to others, and in turn affects the birthing process.

Midwives have a repertoire of skills that enable them to keep birth normal. Sometimes it is not possible to keep birth normal because the decision making or situation is not within the midwife's hands. Keeping birth normal may not be prevention of interventions but rather initiating early "minor" interventions to prevent a ventouse, forceps or a caesarean section. Interventions that are fewer than what they could have been is sometimes all that is possible to achieve within this environment because of the

influences of the doctor, the woman, her family, past experiences, or the birth process itself.

van Manen's (1990) method of thematic analysis was deemed to be appropriate for this study because it originates from the interpretation of everyday lived experience. van Manen stated that "the method one chooses ought to maintain a certain harmony with the deep interest that makes one a [midwife] in the first place" (p. 2). This approach requires a phenomenological or hermeneutic sensitivity to lived experience, and a capability to question the ways in which the world is experienced in a certain way.

The research question that led this study was:

"What are midwives' experiences of keeping birth normal in a secondary care setting?"

This research question has been addressed and, as is often the case in research has raised more questions.

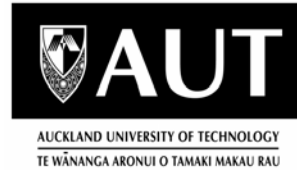
The key findings of this study:

The midwives identified that to keep birth normal they need to nurture the belief in normal birth through the sharing of knowledge and experience. Reflective practice and discussion between colleagues is important to help explore different cases and share how care could be improved next time. "Little rules of thumb" are gifts for junior midwives to help them develop ways to keep birth normal. Even in a secondary care setting it is possible to have midwifery-led care. There needs to be a culture of believing in normal birth. However, maintaining a culture of normal birth within a medically influenced environment is not easy. This needs to be "held", safeguarded and passed forward to other midwives.

There are many times when midwives should be consulting with midwives rather than going directly to the doctor, to enable the strategies of keeping birth normal to be considered before the next step of intervention. Sometimes midwives may intervene with what they consider to be minor interventions to prevent larger interventions such as ventouse, forceps or caesarean sections. There is a necessary balance required to

determine the appropriate timing of intervention. This is gained through experience and the building of knowledge and knowing through everyday practice. This can also be gained from other midwives that have a fundamental philosophy or belief in normal birth. The learning of the mystery of the normal process of birth is gained through “being there”. The insights that are gained are safeguarded by experienced midwives and handed on to the next generation. It is beyond textbooks. It is shared in tearooms, in the moment of an older midwife stepping in, and in the quiet confidence that says, “Just wait a bit longer”. The passion to keep birth normal is so strong that some midwives will still be trying to afford a normal birth for a woman even on the way to caesarean theatre.

The midwives in this study are an inspiration. They demonstrate a quiet yet determined courage to constantly question the decisions that might take away from the “normal” experience. They do not say that intervention is not necessary, but rather, they raise questions about their automatic use, and ask, “Do we really need to do this? Does it feel right? Is there another way?” Such questions keep normal birth a possibility.



Appendix A:

Information Sheet for research participants

The following information outlines the research project that is to be commenced by Deborah Earl through Auckland University of Technology (AUT) for her Masters Thesis.

My name is Deborah Earl and I am a midwife currently working full time in delivery suite at Middlemore Hospital.

My supervisor is Marion Hunter. Marion is a midwife and also a Lecturer at AUT.

If you have any queries regarding this study please don't hesitate to contact us.

Researcher:
Deborah Earl
Delivery Suite, Middlemore Hospital
2760044 ext 8350
Speak.to.Debs@xtra.co.nz

Research Supervisor:
Marion Hunter
Auckland University of Technology
9179999 ext 7365
marion.hunter@aut.ac.nz

The Title of the study is:

What are midwives experiences of keeping birth normal in a secondary care setting?

What is the aim of the study?

To bring to light the wealth of midwifery experience, knowledge and skills that help to achieve normal birth outcomes within a secondary care/hospital setting.

Who can participate in the study?

The participants will be midwives who have worked within a secondary/tertiary hospital unit for more than two years and have also worked in delivery suite. Between 5 and 9 midwives will be asked to be part of the study.

What happens in the study?

If you agree to be part of the study you will be interviewed privately in an environment of your choice, (preferably quiet), and at a mutually agreed time. Your interview will be tape-recorded and will last approximately one hour. During this time the interview can be stopped and started where necessary.

You have a right to refuse to answer any questions during the interview and can feel free to ask any questions that arise during your participation in the research.

The audio-tapes will remain confidential to my research supervisor, myself and a typist who have signed a Non disclosure form. The tapes will be transcribed and a pseudonym (or fictitious name) will be used on all tapes and in transcripts. Your anonymity and confidentiality will be maintained during the study and in any reports or presentations arising out of the study.

Once the data is transcribed, a copy of the transcript will be returned to you so that you can add further comments or delete any part of the interview that you do not want included. The information will be interpreted along with other participant contributions and at the end of the study a summary of the results can be sent to you. Storage of the tapes will be in a locked cabinet and the tapes will be returned to you once the research is complete or they can be destroyed at your request.

What are the discomforts and risks?

Participating in the research is voluntary and you have a right to withdraw from the study at any time prior to the data analysis phase of the study. This will in no way result in any detriment to yourself should you decide to withdraw from the study. You will be required to sign a written consent form prior to participation in the study.

It is hoped that there will not be any risks with participating in the study. However, issues may arise during the interview process that could make you feel uncomfortable, or bring to the surface issues that caused you emotional distress. You do not have to answer all questions and the interview can be stopped at any time. Any information you do not want included in the study can be deleted from the interview transcripts.

What are the benefits?

Most midwives tend to enjoy the opportunity to talk about their practice and stories. Participating in the research process can be rewarding in that practitioners can reflect upon and share their knowledge, skills and expertise.

What happens to the results of the study?

The study will be a Masters Thesis and can be accessed in the Auckland University of Technology Library. As a result of the study articles may be published in relevant professional journals and presented at conferences and seminars. Confidentiality will be maintained at all times.

How long will participating in the study take?

It is anticipated that approximately 2 hours of your time will be required if you participate in the study. The audio-taped interview will take approximately one hour. Additional time will be required to check the transcribed interview and to make any alterations as necessary.

Has ethical approval been obtained for the study?

The Auckland University of Technology's ethics committee has approved this study.

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor Marion Hunter. Concerns regarding the conduct of the research should be notified to the Executive Secretary, AUTEK, Madeline Banda, madeline.banda@aut.ac.nz, 917 9999 ext 8044.

How do I participate in the study?

It is appreciated that you have taken time to read about the study. If you would like to participate in the study or have any further inquiries about the study please contact the researcher Deborah Earl at Middlemore Delivery Suite on 2760044 ext 8350 or by email Speak.to.Debs@xtra.co.nz Thank-you for your consideration.

Approved by the Auckland University of Technology Ethics Committee on 26th of April 2002 AUTEK Reference number 02/24



Appendix B

Consent to Participation in Research

Title of Project: What are midwives experiences of keeping birth normal in a secondary care setting?

Project Supervisor: Marion Hunter
Researcher: Deborah Earl

- I have read and understood the information provided about this research project.
- I have had an opportunity to ask questions and to have them answered.
- I understand that I may ask questions at any time throughout the research process.
- I understand that the interview will be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way. If I withdraw, I understand that all relevant tapes and transcripts, or parts thereof, will be destroyed.
- I understand that any information I provide is completely confidential.
- I agree to take part in this research.

Participant signature:
Participant name:

Date:

Project Supervisor Contact Details:

Marion Hunter, Auckland University of Technology, Private Bag 92006, Northcote. Ph: 9179999 ext 7365, marion.hunter@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 26th of April 2002 AUTEK Reference number 02/24

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