

# New Zealand Midwifery's Journey Towards Autonomy: A Narrative Inquiry

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## Abstract

This thesis explores the experiences of midwives and childbirth advocates who played pivotal roles in the resurgence of midwifery in New Zealand. This movement spearheaded a revolution in maternity, paving the way for the Nurses Amendment Act 1990, the legislation that New Zealand midwives practice under today. These midwives and childbirth advocates redeveloped structures and practices for midwifery and childbirth, which had been subsumed under medicine, and created the core principles of local midwifery: autonomy, partnership, natural childbirth, and continuity of care. Over the course of their careers, they reestablished the midwifery profession by developing the foundations in education, practice, and governance.

Using narrative methodology and methods, based on the categorical-content mode of narrative analysis and the elements of temporality, sociality, and place, this thesis examines the systemic challenges midwives faced throughout the decades, 1980 to 2025. Despite significant barriers, including professional marginalisation and inadequate remuneration, participants demonstrated resilience in upholding holistic, woman-centred care.

The findings outline the historic transition from the medically dominated system to one that briefly sustained midwives and women. However, with the systematic closure of primary units and a rise in hospital births, a fear of physiological childbirth diminished the knowledge of normal birth facilitation. With study participants nearing retirement, and fewer midwives offering primary birthing options, current student midwives are increasingly dependent on hospital-based placements. Furthermore, the New Zealand Ministry of Health continues to provide inadequate and unfair funding for the model of care that threatens to destabilise today's midwifery profession, leaving midwives to recoup their earnings in creative ways, such as fragmenting maternity services. Despite the challenges, the passion and fortitude of participants during their careers is evident.

This thesis underscores the impact of grassroots activism on creating a midwifery-led model of care while revealing how the medical model has gradually undermined these efforts.

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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 (except where explicitly defined in the acknowledgements) (for example, this page), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Date: 19 April 2025

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Signature

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Ngā mihi nui,

Erin

P.S. I have created a playlist of music, a soundtrack, to reflect the timeframe that the research covers "[Erin's PhD Mixtape: Thesis soundtrack. Journey Towards Autonomy](#)" It is publicly available on YouTube.

## Ethics Approval

Ethics approval was granted by Auckland University of Technology Ethics Committee (AUTEK) on 15 December 2022 for 22/360: "Birth of a profession: A narrative inquiry of key informant oral histories into the shaping of midwifery in New Zealand, from 1990 to the present day". (Appendix A)

## Abbreviations

CoM	College of Midwives
GP	General Practitioner
HBA	Home Birth Association
MHBA	Manawatū Home Birth Association
MoH	Ministry of Health
NZMA	New Zealand Medical Association
NZNO	New Zealand Nurses Association
STM	Save The Midwives
Te Tiriti	Te Tiriti o Waitangi / Treaty of Waitangi

# Chapter 1 Introduction

In 1990, New Zealand passed The Nurses Amendment Act, legislation that fundamentally transformed the maternity system. An amendment to the 1977 Nurses Act (Hendry, 2001), this legislation re-established midwifery as an autonomous profession, distinct from nursing, allowing midwives to independently manage antenatal, intrapartum, and postnatal care without legal and mandatory medical supervision. This shift in practice enabled childbirth to remain within the primary healthcare sector, with midwives serving as the principal service providers. In contrast, around this same time, many other countries continued to employ highly medicalised approaches in childbirth, dominated by obstetric hospital-based interventions. As such, New Zealand's midwifery-led model is frequently regarded as progressive and serves as a reference point for nations aiming to reform their maternity services (Davies et al., 2010; Hildingsson et al., 2016).

## 1.1 Rationale and Significance of the Study

In New Zealand, the late 1970s-1980s witnessed a resurgence of women advocating for birthing rights, challenging the prevailing patriarchal medical structures. A grassroots movement was organised by domiciliary midwives and consumer advocates which formed Home Birth Associations (HBAs) and Save the Midwives (STM). Initially considered fringe groups, they rallied significant support and transformed the whole maternity system by getting the Nurses Amendment Act of 1990 passed into legislation (Daellenbach, 1999). The Act marked a pivotal shift, granting midwives professional autonomy and redefining maternity services nationally (Guilliland & Pairman, 2010). However, the home birth rate did not increase to the degree it was expected (Skinner, 2023).

Once The Act's significance was known to hospital midwives, they left employment in droves to work in the community, motivated by financial and autonomy incentives. Equally, the home birth midwives could access hospitals if clinical indication necessitated. However, because the home birth movement arose out of the community to empower women during childbirth, a philosophy was not shared by hospital-turned-community midwives, there was friction (Fleming, 1995). Hospital

midwives subscribed to the medical model and continued to medically manage childbirth as they had in their hospital role (Banks, 2007). The mainstream pregnant woman, at that time, was simply grateful for continuity of care with a midwife, as she was not aware of the differing practice between previous hospital midwives and the home birth midwives (Christison, 2001). As such, the differing philosophies required integrating into a collective unified profession (Guilliland, 1999).

Despite midwives overseeing a significant portion of maternity services, from 1990 until 2023 the management of labour and birth became significantly more medicalised, eroding traditional midwifery practices (Skinner, 2023). Childbirth was often portrayed as a hazardous event requiring hospitalisation and requiring medical interventions, which had implications for both women and midwives.

As the current system was constructed by home birth midwives and childbirth activists, 'consumers' whose philosophy strongly aligned with natural childbirth, this research set out to investigate their experiences of getting The Act passed, their extensive careers, and the changing landscape of the profession over time. This study contributes to existing literature focused on the College of Midwives (CoM) (Pairman, 2005; Guilliland & Pairman, 2010), testimonies from domiciliary midwives (Banks, 2007), consumer involvement (Christison, 2001; Daellenbach, 1999; Donley, 1992a), and midwifery direct entry education (Pairman, 2006).

This research captures the experiences of midwives and consumers who were instrumental in fighting for independence provided by 'The Act', after which this small group developed the local profession. They created midwifery frameworks, such as the Standards Review process, the College of Midwives, negotiated for pay equity, and developed direct entry education. This research addresses their personal and professional experiences over the course of their careers.

This narrative inquiry examines historical concerns and transformations within midwifery that remain profoundly relevant to the profession today and into the future, in Aotearoa New Zealand and globally. By tracing midwifery's evolution through periods of legislative, cultural, and systemic change, the research uncovers enduring patterns of resistance, adaptation, and resilience. These insights illuminate how past struggles and triumphs continue to shape present-day practice, particularly in relation

to medicalisation, professional autonomy, and the sustainability of midwifery-led care. In doing so, the study demonstrates how reflective engagement with the past can inform more responsive, evidence-based, and woman-centred models of care.

Visiting these participant's narratives reinforces professional identity and collective memory, grounding midwifery in its core values of relational, holistic, and autonomous practice. In an era increasingly defined by technocratic and risk-driven approaches, this historical lens empowers midwives to articulate the value of continuity of care and to advocate for its preservation and evolution. Positioned within an international dialogue, New Zealand's experience offers a compelling case study of professional renewal within a medicalised landscape. Ultimately, this work shows that narrative inquiry not only preserves the legacy of midwifery but also mobilises it; serving as both a mirror and a catalyst for a forward-looking, contextually grounded, and resilient profession.

## 1.2 Research Objective, Aims, and Questions

The focus of this research examines the experiences of individuals who identify as women, midwives, and consumers who developed a women-centred maternity service within a patriarchal medicalised environment and under the umbrella of a patriarchal society. Using a narrative inquiry approach, informed by Clandinin and Connelly (2000), this research examines the New Zealand midwifery system and the participants' experiences over that time.

The research objectives identified in this study are to explore the experiences of individuals who were involved The Amendment Act, 1990. The research questions presented, guided the narrative inquiry. The initial question guiding the research was around the aspirations the study participants had for maternity care, and asked 'how did they envision their role in shaping its transformation?' The additional questions were prompted as the study matured.

### 1.2.1 Study Aims

- To critically examine the experiences of those who spearheaded the legislative changes in 1990 that established autonomous midwifery in New Zealand, with a particular focus on the challenges and motivations.

- To analyse how these formative experiences have shaped the evolution of midwifery as a profession, influencing both clinical practice and midwifery education in the present day.
- To explore the broader socio-political and institutional influences that have impacted midwifery over time, as understood through the perspectives of the participants.

### 1.2.2 Research Questions

- What aspirations did these participants have for maternity care, and how did they envision their role in shaping its transformation?
- How did participants experience the maternity system prior to The Nurses Amendment Act 1990; what challenges did they encounter?
- How did participants navigate their professional relationships with other maternity care providers, and what influenced these interactions?
- How did the formal professionalisation of midwifery impact the financial sustainability and autonomy of independent midwives following the passing of The Act?
- What challenges did midwives face in securing recognition and legitimacy as primary maternity care providers within the healthcare system?
- How have participants sustained their commitment to physiological birth and midwifery autonomy over time, despite systemic constraints and professional marginalisation?

### 1.2.3 Study Impact

The expected impact of this study reflects the contemporary challenges within a continuum of struggle and reform. In absence of identifying the historic context, present-day concerns in the midwifery system could be considered isolated problems rather than the enduring power relations. The factors which constrained midwives before the 1990 Amendment Act, control, surveillance, and the privileging of the medical model, continue to influence maternity care today within New Zealand but also globally.

### 1.3 Overview of Theoretical Framework

It is important that the philosophical underpinnings of this research are addressed here as prior to The Act midwifery in New Zealand struggled for independence under the dominance of medicine. Within a research context, often investigations which have a clinical or health focus employ a positivist methodology (De Vore, 1995). Research underpinned by a positivist framework, or scientific method, is understandably a useful tool to assist in answering problem-based clinical questions (Clandinin & Rosiek, 2019). However, there are limitations to a positivist approach when the focus of the research is to understand individual experiences of phenomena or to gain insight into the nature of a phenomenon (Josselson & Hammack, 2021) as the theoretical underpinning guides the types of questions asked and answered of the research and by the researcher.

Most qualitative research is situated between realist and relativist paradigms (Denzin & Lincoln, 2000). To better understand the nature of 'reality' or ontology, and how thinking about it is framed, or epistemology, it is beneficial to set out the lens under which the research was carried out. Both ontological and epistemological positioning are important to understand as they shape the decisions around which methodology to use (Nightingale & Cromby, 2002).

While ontology is examining the nature of reality, epistemology is concerned with how one might go about exploring reality and how one comes to understand anything (Crotty, 1998). The question ontology tries to answer is, 'what is reality'? Epistemology outlines how someone understands knowledge, their thinking practices, and how they think other people know and understand reality. This research is framed within a critical realist ontology, social constructionist epistemology, and a critical feminist lens. It examines how power and control have affected the dynamics of maternity services, for women and midwives, over time.

Bhaskar (1998) attested that critical realism argues against historic philosophical ideas around disorder. Stating that social structure is perpetuated by free-choice and human agency helps to understand how social structures develop and are maintained. As an epistemological approach, critical realism is situated between realism, accepting reality as what has been observed; and social constructionism, taking reality as constructed

through society's attitude (Nightingale & Cromby, 2002). Critical realism accepts epistemological relativism (Bhaskar, 1998), meaning that how we understand the world is socially constructed through interactions with others with whom we engage (Proctor, 1998). Critical realists acknowledge ontological realism and hold the belief that there are 'side effects' from certain structures, which create something that can be observed (Bhaskar, 1998).

Social construction positions itself in that one's worldview develops through the narratives that person holds, what they understand to be morally correct, rational, and true, as stems from historical and cultural social experiences (Gergen, 2011). These may be narratives in the form of stories people tell themselves or that are shared with each other. Despite people's tendency to believe these narratives as 'truths' they are not a universal 'truth' that can be understood as based in one fixed reality (Burr, 2015). Burr (2015) also argued that social constructionism challenges the 'taken-for-granted' knowledge which one's knowledge has been founded on and suggested that one should be suspicious of how the world appears to be. Further, the constructionist view attests that one's understanding of the world and oneself stems from human relationships; hence, they are socially constructed (Gergen, 2011).

Narrative research is grounded in a social constructivist philosophy, recognising that meaning is shaped as individuals articulate their experiences through their own words. This practice has the potential to capture complexities in their experiences (Ntinda, 2019). Rooted in subjugation and subjectivity (Weir, 2021) they relate to gender discrimination and patriarchal structures within the socially constructed world (Grant & Osanloo, 2014).

#### 1.4 Thesis Outline

This study explores the experiences of successfully changing the maternity system within New Zealand. The participants share experiences of this achievement and identify how they developed the woman-centred service which continues to be the maternity service model in 2025. Drawing on narrative inquiry methods, these in-depth qualitative interviews were conducted to explore how participants made sense of their experiences within midwifery services across time.

Chapter 2 presents the historical and socio-cultural background and context for the study. Chapter 3 presents a brief narrative review of the literature to identify what is known about The Act. Chapters 4 and 5 outline the methodology and methods used in the study respectively.

Chapters 6 through 10 showcase the findings of the study. The first of the findings chapters reveals participant experiences of working within maternity services or as a health consumer before the 1990 Act passed, identifying why changes were needed. The research questions outlined in Chapter 6 are: What aspirations did these participants have for maternity care, and how did they envision their role in shaping its transformation? and How did participants experience the maternity system prior to the enactment of the Nurses Amendment Act 1990, what challenges did they encounter?

Chapter 7 focuses on the midwives outlining how they learned to trust birth and changed their beliefs around childbirth leading to their practice and paradigm shift. The research question set out within this chapter was: How did participants navigate their professional relationships with other maternity care providers, and what influenced these interactions?

Chapter 8, the third findings chapter, presents how midwives have been othered within the health system, and society at large, leading the justification for the MoH to abdicate their responsibility to pay midwives equitably. The research question posed in this chapter was: How did the formal professionalisation of midwifery impact the financial sustainability and autonomy of independent midwives following the passing of the Act?

Chapter 9 outlines the breakdown of midwifery services resulting from devaluing midwives through withholding of fair economic reimbursement. This chapter set out to answer the research question: What challenges did midwives face in securing recognition and legitimacy as primary maternity care providers within the healthcare system?

Chapter 10, the final findings chapter, presents that despite marginalisation and financial controlling, participants have continued to maintain their deep-rooted

connection to the empowerment that natural childbirth offers. Their strategies used to protect traditional midwifery across the country are outlined. The research question addressed in this chapter was: How have participants sustained their commitment to physiological birth and midwifery autonomy over time, despite systemic constraints and professional marginalisation?

Chapter 11 is a detailed discussion of the findings, implications, and further research recommendations. The chapter ends with an outline of the limitations and strengths of the study.

## Chapter 2 Research Background and Context

*Back in the late 1980s I was a health minister. One of the things I got to do was legislate through parliament for our midwives to practice autonomously. I really believe in that. I believed that the midwife was very, very capable, competent and professional and should be able to work with a woman and her family right through the birthing process. Today in New Zealand this almost seems like ancient history, because almost everywhere the birth is conducted by the midwife. But it was a huge breakthrough going back more than 25 years, and one I'm proud of. (Helen Clark, 2018, p. 289)*

This chapter outlines the rationale and motivations which drove both consumers and domiciliary midwives to advocate for changes in childbirth within New Zealand.

Midwives and consumers alike emphasise a distinction between doctors and midwives, particularly regarding their approach to childbirth. Historically, traditional midwives approached pregnancy and childbirth through a physiological lens, viewing reproductive health as a life process; whereas a medical approach, primarily managed by obstetric nursing staff, used routine clinical procedures (Ehrenreich & English, 1972). Consequently, in New Zealand the role of the midwife shifted from a practitioner who focused on supporting the natural progression of labour to that of medical staff managing labour through prescribed tasks (Banks, 2007).

The sections of this chapter set the context and background to examine the pre-development of maternity care in New Zealand. They are presented linearly from early colonisation through to the 1980s. While a broader global feminist movement was also gaining momentum during this period, and a brief reference to this international sentiment is made, the focus of this chapter intentionally remains confined to the New Zealand context. This approach is deliberate, as it aims to provide a historical and cultural evolution of midwifery-led maternity services in New Zealand. This way, full comprehension of participants' experiences from the 1970s and onwards can be contextualised and better understood.

The chapter closes by examining the medical fraternity's attempts to undermine the personal and professional autonomy of both women and midwives. Specifically, it examines the deliberate actions taken by the New Zealand Medical Association

(NZMA), who sought to suppress independent midwifery, viewing it as a competitive threat to their financial interests.

## 2.1 A Brief History of New Zealand Midwifery: 1904–1990

*Today New Zealand's maternity services are a shambles. Women are fighting to reclaim their bodies, their babies and their birth experiences; midwives are struggling to regain their profession.*  
(Donley, 1986, p. 121)

The historical accounts presented in this chapter reveal significant cultural shifts that contributed to the medicalisation of childbirth (Clarke, 2015), and the experiences of Indigenous Māori and Pākehā (non-Indigenous New Zealanders) in the early 19<sup>th</sup> century highlight the evolving dynamics of childbirth practices. Reports from the early 1800s indicate that the first qualified midwives were missionary women who attended births within their own community. New Zealand was the first country in the world to legislate nursing through the Nurses Regulation Act of 1901 (Papps & Olssen, 1997), indicating strong historic medical oversight in the governance of the nursing and midwifery professions (Able, 1997).

The Midwives Act of 1904 formalised midwifery education, established a register, and outlined the legalities of practice (Clarke, 2015). Reportedly, the 1904 Act was introduced in response to concerns that new immigrants that attended births for fees, were not considered to be of 'good character'. The 1904 regulations were implemented to ensure that only women who were deemed 'suitable' were permitted to practise (Papps & Olssen, 1997). While this 'Act' granted midwives legal status to attend births without a doctor, its primary purpose was to control and monitor midwives through the requirements to maintain registration (Papps & Olssen, 1997).

In 1905, the first St Helen's Hospital opened (Clarke, 2015), marking a significant shift in the culture of childbirth for both women and midwives. The establishment of St Helen's, coupled with midwifery regulation, the rise immigration, and a lack of family planning, led to New Zealand's first workforce shortages in midwifery. St Helen's formalised a 12-month midwifery training programme, or 6-months for a qualified nurse (Clarke, 2015). St Helen's was marketed as a respite for working-class women, relieving them of household duties and recovery from childbirth (Mein-Smith, 1986).

Being a private maternity hospital managed by women, St Helen's was not accessible to medical students or private doctors, provoking strong disapproval from the British Medical Association and Otago's medical school (Dobbie, 1990).

Wāhine Māori (Indigenous Māori women) reportedly experienced very low maternal mortality rates prior to colonisation. Traditional birthing practices were widely utilised (Kingsford, 1933) and babies breastfed well into toddlerhood (Hooker, 1869). These practices continued in the home setting until the passing of the Tohunga Suppression Act in 1907, which effectively eliminated Māori healing traditions, including those related to childbirth (Te Huia, 2015). The 1907 Act threatened imprisonment to anyone practicing Māori healing methods; thus, diminishing the continuation of traditional Māori birthing knowledge. The introduction of hospital births saw an increase in maternal and perinatal mortality rates among Māori, surpassing the European population. This rise was largely attributed to the onset of disease, land confiscation, and the impacts of war, which accompanied colonisation (Whiteside, 1982). Consequently, Māori healing methods, including natural childbirth, have yet to be fully reestablished (Te Huia, 2015).

Stojanovic (2008) identified three major factors that shaped maternity services in New Zealand between 1904 and 1971: hospitalisation, the 'nursification' of midwives, and the medicalisation of childbirth. The introduction of hospital births standardised labour and delivery processes, reducing the scope for individualised service and diminished the role of midwives as traditional knowledge holders of birth. As medical interventions became more routine, the role of midwives shifted from managing labour processes to following standard orders (Donley, 1986). Hospitals implemented the widespread use of medications and restricted food intake for women in labour. It was reasoned that any food in the stomach posed a potentially fatal risk of vomiting and asphyxiation while unconscious (Singata, Tranmer, & Gyte, 2013) because of the high doses of medication rendered to patients.

However, medical approaches overlooked the physical demands of labour. Like athletes in a marathon, women in labour require nourishment to sustain their energy (Beggs & Stainton, 2002). Traditional midwifery practices, in contrast, encouraged women to eat and drink during labour to maintain strength and alleviate the pain

sometimes associated with hunger. In hospitals, the restriction of food often resulted in women lacking the energy to push effectively, increasing medical interventions such as intravenous fluids and instrumental deliveries (Stojanovic, 2008).

Papps and Olssen's (1997) Foucauldian discourse analysis provides a historical account of how midwives were systematically marginalised in New Zealand childbirth practices between 1904 and 1990. They argued that the medical hierarchy exerted power over women and midwives through mechanisms of fear mongering and surveillance, effectively exerting control in labour and birth. Obstetric lobbying played a pivotal role in shaping public perception by promoting the belief that hospital births were inherently safer (Stojanovic, 2008; Mein-Smith, 1986) and emphasising the risks of what 'could go wrong' during labour (Papps & Olssen, 1997). Paradoxically, many complications attributed to childbirth arose from iatrogenic events, issues caused by medical practitioners or interventions, highlighting the consequences of medicalisation (Donley, 1986).

Increasingly hospital births became common; in part, driven by the general belief that women suffered from nervous exhaustion due to fears and pains of childbirth requiring operative procedures (Breitstein, 1915). However, the introduction of government-funded stays (Dobbie, 1990) also facilitated a shift from traditional upright and active labour practices to the adoption of the lithotomy position (Donley, 1986) which coincided with an increased demand for pain medication (Papps & Olssen, 1997). Physicians administering medications charged additional fees, which contributed to their perceived credibility over midwives (Woolcock, Thearle, & Saunders, 1997). The heavy use of medication also significantly increased the workload of nurses and midwives who were tasked with monitoring its effects on both women and neonates, rather than observing the progression of labour.

Commonly used drugs, such as nembutal and scopolamine, rendered both mother and foetus unconscious, necessitating constant foetal monitoring. Doris Gordon, an obstetrician at Otago's medical school, championed scopolamine and morphine for 'twilight sleep' (Jones, 2016). Inspired by practices she observed in Britain, Gordon argued that women should have access to hospital births equipped with the latest

technologies (Donley, 1986). As these medical approaches became the norm, medical schools implemented student training on unconscious patients (Stojanovic, 2008).

The institutionalisation of childbirth further entrenched the perception of labour and delivery as pathological processes necessitating medical intervention among both practitioners and the public. Public opinion regarding pain during labour, which had traditionally been managed through midwife support, was then considered as necessitating treatment (Firkin, 2003).

The introduction of scopolamine and morphine soon became routine medication which continued throughout labour and, in some cases, after delivery. During the second stage of labour, chloroform was routine medical treatment. The sedative properties of these medications impeded practitioners' ability to assess patients' behaviours, traditionally utilised to evaluate the various stages of labour.

Consequently, rectal and vaginal examinations were performed by practitioners to monitor cervical dilation and labour progression (Papps & Olssen, 1997) rather than traditional methods of monitoring the patient. Such examinations were often done without the patient's consent, as many women were semi or fully unconscious (Stojanovic, 2008).

Once fully dilated, women were unable to push effectively. Although the use of high forceps declined, there was a corresponding rise in caesarean sections (Mein-Smith, 1986). The widespread adoption of chloroform fundamentally transformed labour management by diminishing maternal participation, further increasing the necessity for medical interventions throughout labour and delivery (Woolcock, Thearle, & Saunders, 1997). Including continuous foetal monitoring, pelvic examinations, caesarean deliveries, and even the physical stimulation of neonates increased (Edwards & Jackson, 2017).

These routine procedures, although intended to improve outcomes, increased the risk of cross-contamination and the spread of bacteria, leading to higher rates of maternal mortality (Stojanovic, 2008). Manual removal of the placenta increased further significantly heightening the risk of infection (Mein-Smith, 1986; Molloy, 2017). Instrumental deliveries contributed to an alarming increase of maternal mortality due to puerperal fever and sepsis.

Despite clear evidence linking these outcomes to interventionist techniques (Molloy, 2017), the medical fraternity blamed midwives who prepared medications (Stojanovic, 2008). The escalation in medical interventions also transformed designated duties for nurses and midwives. Instead of providing continuous support to women during childbirth, their responsibilities were reduced to summoning doctors for deliveries. Attributing blame to midwives effectively diverted attention from the potential dangers associated with medical interventions and medications (Mein-Smith, 1986) and simultaneously reinforced a perceived necessity for medical management among the public.

As maternal mortality rates continued to rise, the State chose not to revert to primary maternity homes or support home births. Instead, it reinforced the trend towards medicalised childbirth and funded a 14-day postpartum hospital stay (Griffin, 1994). This policy further entrenched medical dominance in maternity by expanding the obstetric funding (Firkin, 2003).

As infections increased, physicians implemented stricter aseptic techniques intended to improve safety but which simultaneously constrained midwives' role (Donley, 1986). New protocols included transferring women in advanced labour to sterile delivery rooms (Hedwig, 1990).

Medicalisation of childbirth had a profound shift in societal consequences. Over the span of 15-years the proportion of hospital births rose from 35% in the 1920s to 78% by 1935 (Mein-Smith, 1986), despite the traditional, community-based midwifery care that had been the norm in previous generations. Although the sepsis rate did decline, Bonham (1964) indicated,

no one could say how much was due to the development of antiseptic and aseptic care with associated maternity regulations, how much to the loss of virulence of the organism and how much due to a change in population resistance. (p. 713)

In promoting technology and medication, hospital birth was seen as both a symbol of social status; however, it offered a false sense of 'protection' against contracting infection. Alternatively, home births, where midwives only attended to one person, posed zero risk of infection from cross-contamination (Papps & Olssen, 1997).

Medical domination shifted the discourse from a patient-centred approach to one rooted in 'risk'. This rhetoric was driven by the complications which were introduced with medical interventions and further reliance on technology (Papps & Olssen, 1997). The emphasis on perceived dangers marginalised ancient and traditional midwifery practices, undermining both women's confidence of their natural birthing abilities and practitioners' trust in physiological childbirth (Donley, 1992).

During the 1920s, approximately 65% of working-class men paid for their wives to deliver at home or in modest, often unlicensed, maternity homes (Stojanovic, 2008). These facilities were frequently small rooms annexed to the midwife's residence and maternal outcomes were comparatively better.

Around 1925, the New Zealand Medical Society assumed authority over designing and grading the nursing state examinations (French, 2001). This control reflects the broader subjugation of midwifery and nursing to medical oversight.

The 1920s and 1930s, due to economic hardship from the Great Depression increased a trend in women, who unable to afford the fees imposed by doctors, seeking out midwives as an economical option (Donley, 1986). However, also during this period, which coincided with the first wave of feminism, a trend amongst wealthier women was to leverage their social standing by advocating for publicly funded hospital births, ensuring such care accessible to all women (Mein-Smith, 1986).

By 1938, 81% of European babies in New Zealand were born in hospitals with doctors and obstetric nurses (Donley, 1986). During this period, smaller rural maternity homes continued to close with primary care absorbed by larger hospitals (Donley, 1992). The need for 'obstetric nurses' was reinforced by Professor Dennis Bonham, the Chair of Postgraduate Obstetrics and Gynaecology at Auckland University clinical school, National Women's Hospital (Donley, 1998b). In response to persistent staffing shortages, obstetric nursing training was consolidated into general nursing education, incorporating a curriculum focused on highly technical, task-oriented skills. Students were required to perform 20 internal examinations during labour, administer 10 anaesthetics, and oversee 5 deliveries (Dobbie, 1990). The emphasis on learning technical skills increased a reliance on technology, while simultaneously diminished the intellectual and holistic elements of midwifery practice (Hedwig, 1990).

### 2.1.1 Traditional Midwifery Perspective

Donley (1998a) argued that home births offered a relaxed and supportive environment. In a home setting, the woman's needs and wishes are prioritised, allowing her to remain the central focus of her birth experience, while maintaining personal authority within the process (Griffin, 1994). Banks (2007) outlined that a midwife in home birth settings offers suggestions and explanations but, ultimately, the woman makes the final decisions. This approach aligns with traditional birthing practices of Indigenous Māori wāhine that emphasise a holistic and individualised experience (Whiteside, 1982).

The traditional birth attendant or midwife views pain in childbirth as a natural and integral part of the birthing process, rather than something to be feared or removed (Leap, 1998). Pain serves as a physiological signal, prompting the individual to seek a safe space for delivery (Lowe, 2002). Midwives support and empower the labouring woman by guiding her through the experience, helping her trust in her body's abilities and embrace the sensations of labour as part of the birth journey. This perspective empowers women in navigating their birth experiences (Guilliland & Pairman, 2010).

Hospitals provide treatments for sick individuals; therefore, the standard medical approach to labour and birth often contradicts the traditional midwifery philosophy. Hospital protocols prioritise medical procedures over the patient's preferences. Hunter (2000) described the impact of hospital procedures on midwifery autonomy by likening hospitals to factories operating on assembly lines, with labour and birth managed with a series of standardised tasks. The hospital environment, structured on a pay-for-time model (Firkin, 2003), prioritises efficiency of treatments over personalised care. This often results in 'on-duty' midwives being more focused on clock time than on providing patient-centred support (Skinner, 2023).

In an illustration of the routine hospital approach, Earl (2004), a midwife, recalled the story of her mother's birth in the 1950s. Despite having had a planned home birth, her mother went to the hospital to take advantage of the government-funded postnatal stay. Upon admission, she was subjected to the full suite of routine hospital procedures; promptly receiving a pubic shave and enema while her newborn was admitted to the nursery (Earl, 2004).

Donley (1992) related the closure of small maternity hospitals, which traditionally employed midwives, to the medical establishment's monopoly on childbirth. This shift both increased reliance on technology for all births and a decline in midwifery skill. Donley emphasised that the contrasting perspectives between obstetricians and midwives stem from their professional experiences which shape their approach to care. For instance, Auckland obstetrician, Dr. Mantell, described labour as a "time of greatest risk for the baby" (Donley, 1992, p. 4), noting that he considered himself an advocate for babies rather than mothers.

While Dr. Mantell's intentions may appear noble, his statement reflects a narrow focus on the foetus, with the mother as secondary. Yet, obstetricians are responsible for the mother's well-being. While obstetricians concentrate on maternal health during labour, the foetus' well-being remains intrinsically linked to the mother. Dr. Mantell's characterisation positions the mother as merely a 'host' and reflects a view that the woman is primarily a vessel for a foetus, which diminishes her personal autonomy and agency in the childbirth process.

This attitude reflects a medical model that disregards women's desires, thereby justifying a lack of informed consent in healthcare services (Coney, 1997). Domiciliary midwives and consumers of maternity services were particularly vocal in challenging this view, advocating for a more holistic and woman-centred approach to childbirth (Daellenbach, 1999; Donley, 1998a). Sally Pairman, a prominent New Zealand midwife, captured this shift, stating that "midwives really make a difference to women's experiences. We are not just there beside the woman. There is an active part about being a midwife that impacts on the woman... either positively or negatively" (Ogonowska-Coates, 2004, p. 64). Pairman's statement highlights the partnership model where midwives employ a woman-centred approach, focusing on woman's well-being and dignity, which contrasts with the more paternalistic model reflected in the medical model.

### 2.1.2 Building to Change

The trend of institutionalised childbirth continued into the 1960s, with only around 25% of births occurring in primary maternity centres (Donley, 1992). Large hospitals became the dominant setting for childbirth, where episiotomies and forceps were

normalised, and breastfeeding rates declined (Donley, 1998a). Babies born by forceps were subjected to strict cot treatments, prohibiting parental contact, which further disrupted breastfeeding and bonding (Donley, 1998a). Standard procedures included rigid breastfeeding schedules, often limiting infants to 1-minute per breast (Carolyn Young, personal communication, 12 May, 2023). Practitioners became over-reliant on scales for monitoring infant weight and increased bottle feeding, as this was easy to measure, although it affected women's confidence in successful breastfeeding (Dobbie, 1990).

In 1971, after 64 years of independent midwifery, the Nurses and Midwives Act was modified to the Nurses Act, which placed the registration of midwives under the authority of medical practitioners (Papps & Olssen, 1997) and reduced the midwife to an obstetric nurse. A midwife followed directions as medical practitioners were responsible for patients. Exceptions were made for an emergency, otherwise the midwife could be fined NZ\$200 (Donley, 1989b). Responding to staffing shortages, the Nursing Council called for midwives to train as obstetric nurses (Donley, 1986). The government reduced funding for domiciliary midwives which saw a corresponding decrease in access to home births (Banks, 2007). The impact of these changes was stark. In 1971, there were 87 home births nationally, but by 1972 this number had plummeted to 24 (Daellenbach, 1999). Domiciliary midwives were most affected by this change, as it was noted, "painless childbirth has always been a seductive carrot for doctors to maintain control of the lucrative high-tech birth market" (Donley, 1998a, p. 10). The universal hospitalisation of birth profoundly affected midwives' practice, as women were 'hospitalised' and midwives institutionalised. Instead of being 'with women' they became 'with machines', and their practice was spent trying to mitigate adverse effects of the technology (Beech, 1998).

Banks' (2007) research on domiciliary midwifery practice between 1974 and 1986 highlighted hostility faced by domiciliary midwives and home birth women from hospital-based practitioners. In response, both domiciliary midwives and childbirth consumers established formal networks of support through local and national HBAs. These networks were families who had, or were planning, home births, and included a small number of domiciliary midwives (Donley, 1986). The expanding support network emerged in response to the increasing marginalisation of midwives and reflected a

shared commitment among both consumers and midwives to reclaim autonomy in childbirth while preserving an alternative to the dominant hospital-centric model.

Skiff (2014) offered a contrasting perspective of declining midwifery autonomy. Examining hospital-based midwives working under medical authority from 1950 to 1990, Skiff interviewed eight participants to explore the extent of their professional autonomy in hospital settings. The midwives reported making decisions that were often influenced by staffing levels or clinical risk; Skiff contended that, despite the apparent constraints on their autonomy, these midwives employed various strategies to assert their professional judgment. Although the participants' responses identified clear limitations to their autonomy, they used manipulation to overcome the power dynamics and assert their influence. The research highlighted ways in which the constraints of medical authority affected midwives.

Many midwives would ask questions of the doctor if something negative arose and would confront the doctor to give them her opinion. However, because midwives were lower in the hospital hierarchy than their medical colleagues, and were no longer autonomous practitioners after 1971, confrontation was not always a viable solution to a problem. As a result, midwives developed techniques to manage negative situations and disagreements that arose with doctors, to ensure that women and babies got the type of care midwives determined they needed. (Skiff, 2014, p. 40)

Skiff's (2014) argument that obstetric nurses operated as autonomous professionals challenges the broader definition of autonomy as the capacity for self-determination, as outlined by Pairman (2005). According to Pairman's definition, autonomy in professional practice entails the ability to make independent decisions and exercise judgment, rather than being bound by the obligation to carry out a prescribed set of routine tasks at specific stages of care (Moloney, 1992). An autonomous midwife, for instance, exercises professional judgment, making decisions based on comprehensive assessments and employing intellectual tools such as informed consent and differential diagnosis (Pollard, 2003). Skiff's research, however, overlooked the potential consequences that midwives might face for failing to adhere to prescribed routines. One participant acknowledged that hospital procedures at the time were

highly regimented, “very, very strict, and we were certainly, that was part of our practice, to adhere to the regulations” (Skiff, 2014, p. 24). Skiff did not address disciplinary measures which could have been imposed on midwives who deviated from established protocols. This omission is significant, as it calls into question her argument and identifies the limitations of midwives’ professional autonomy.

The 1970s and 1980s saw obstetricians advocating for implementing routine early rupture of membranes, episiotomies, and low-forceps deliveries (Dobbie, 1990). Additionally, Professor Bonham circulated a paper outlining a ‘high-risk’ list, (Appendix F) outlining explicit conditions or factors necessitated obstetric referrals for all first pregnancies, any complications in the current pregnancy, women over the age of 30, and those with a history of stillbirth or neonatal death (Earl, 2004). This broadened the clinical definition of obstetric risk and was strategically designed to include most pregnancies; thus, ensuring a steady flow of patients to meet the training needs of obstetric students (Coney, 1983). However, these attempts did not go unchallenged. Women resisted, arguing that the risk list unnecessarily categorised women, pushing them into specialist obstetric care (Dobbie, 1990; Donley, 1998).

In addition to the medical school requiring patients, there was financial incentive for obstetricians to impose upon all pregnancies (Donley, 1998). General practitioners (GPs) and domiciliary midwives were restricted from collecting additional maternity fees from patients; whereas obstetricians could charge patients a standard fee, while also collecting payment from the State (Firkin, 2003). The more complex the pregnancy, the higher the fees collected by doctors. Hence, it was in their financial interest to continue the ‘risk’ narrative (Banks, 2007). In 1986, domiciliary midwives were paid 40% of the GP’s fee for the same role, with no consideration of the additional four to six times that midwives spent attending women in labour (Banks, 2007). After a change in the fee structure, which further increased pay inequity, obstetricians and general practitioners were paid by the half hour to attend labour; whereas domiciliary midwives were paid by the hour (Larkin, 1984a). Even if the domiciliary midwife fee doubled, the cost for a homebirth would still be just over half of the cost of the hospital birth (Ogonowska-Coates, 2004).

By the 1970s, the term 'midwife' had virtually disappeared from New Zealand's language. All practitioners were referred to as 'nurse' (Fleming, 1996). While St Helen's hospitals graduated around 150 midwives annually, the closure of smaller maternity hospitals meant fewer midwifery training units were available. Maternity education was integrated into the Advanced Degree in Nursing. Between 1981 and 1987, only 23 midwives graduated, and the clinical training provided was considered insufficient for performing basic midwifery tasks (Skinner, 2023). By 1980, a further 33 primary birthing units were closed. Hospital boards cited safety as the reason, although no evidence was provided supporting their claims (Skinner & Lennox, 2006). In contrast, the home birth community, relying on its own data, demonstrated that home births had a lower mortality rate, four per 1,000 births compared to 14 per 1,000 in hospitals (Coney, 1983), although, the hospital statistics likely included cases where the mothers or babies were not suitable candidates for home birth.

In 1982, there was a modest 1% increase in home births, rising from 350 in 1981 to 461. In response, the Auckland hospital board established the Maternity Services Committee (MSC) to review the safety of childbirth (Coney, 1983). The 15-member committee consisted of 12 men, seven were obstetricians. Questions were raised regarding diversity of representation and perspectives. However, the MSC report, which took 3-years to complete, ultimately concluded that hospital birth was the only safe option and drew heavily on United Kingdom (UK) statistics. In Coney's (1983) critique of the report, she pointed out that the UK data were misleading, all maternal deaths during pregnancy and up to 42 days postpartum were included, capturing fatalities from causes such as car accidents, homicide, and suicide. The neonatal outcomes were also inaccurate as all out-of-hospital births had been tallied. Babies born in taxis and remand homes were not distinguished between planned home births attended by skilled midwives. The report recommended that domiciliary midwives be reviewed by hospital boards rather than the public health departments, and that midwives should be 'certified' by senior obstetricians with recent hospital experience. This recommendation, combined with the falling birth rate and the modest rise in home births, inspired Coney's statement, "the spectre of empty beds haunts the obstetric empires" (p. 6).

An evaluation was conducted of the small birthing units and was promptly embargoed. The work, led by Professor Rosenblatt (1984) from the University of Washington and Dr Judith Reinken from the Department of Health in Wellington, assessed the safety and efficacy of primary birthing facilities. Their findings were significant; small maternity hospitals were well-utilised, safe, and had better maternal and neonatal outcomes compared with larger hospitals (Rosenblatt, Reinken, & Shoemack, 1985). There were robust referral guidelines in place and prompt transfers of patients when clinically necessary. However, by the time the Rosenblatt report was published in 1985, these small units had already been closed; indicating the plan was to close the small hospitals all along (Donley, 1998a).

By 1983, New Zealand was facing a critical midwifery shortage (Dobbie, 1990). The Auckland hospital board closed an additional five primary birthing units; again, identifying 'safety' as their key concern, despite all evidence to the contrary (Donley, 1986). Suitable candidates for minimal interventions were subjected to costly and clinically unnecessary treatments in large hospital settings, which were now the only option (Donley, 1992). Women could choose to have a home birth if they could secure both a domiciliary midwife and a supportive GP. Hospital midwives were increasingly overworked due to staffing shortages, exacerbated by the closure of smaller, community-based training units. However, beneath this tide of medicalisation, a midwifery renaissance was quietly gaining momentum. Midwives, alongside consumers, were beginning to challenge the prevailing paradigm, creating a foundation for advocacy and change.

The following sections—Consumer as Comrade, Save the Midwives, and The Home Birth Association—examine the grassroots activism of natural childbirth advocates and domiciliary midwives' efforts to regain professional autonomy. These activists played a crucial role in advocating for midwives and home births, aligning themselves towards a broader movement for change in maternity care. The section, the Unfortunate Experiment (section 2.2.2), addresses the allegations against a prominent obstetrician and professor who, between 1966 and 1984, withheld standard treatments to women with cervical cancer and, instead, observed their health decline. The inclusion of this section serves to illustrate the doctor-patient relationship around that time and to highlight the systemic failure of a hospital which, for nearly 2-decades, remained silent

and protected doctors who were responsible for patient mistreatment. This inquiry became a catalyst for widespread dissatisfaction with institutionally driven approaches to reproductive healthcare in New Zealand. It galvanised women to challenge the status quo, actively lobby for reforms, and demand accountability measures for medical institutions.

During this period women had limited choices in maternity services. Pregnant women were left wondering where they could safely give birth, who would attend them in labour, and who would care for them postnatally. Women were often denied the presence of their husbands during labour and birth, and hospital staff maintained strict adherence to policies and procedures. Women began to question standard practices, expressing a desire for involvement in their own health decisions (Banks, 2000). Many women began to resist routine interventions and the use of heavy medications, advocating instead for more natural childbirth methods. They also sought to have their families involved and requested that their newborns 'room in', rather than being taken to the nursery (Dobbie, 1990; Whiteside, 1982).

Domiciliary midwives and women had clear and straightforward requests. Consumers, as the recipients of maternity services, sought to have more agency over their healthcare. Domiciliary midwives, in turn, sought recognition for the professional responsibility they carried, requesting remuneration that accurately reflected the level of service they offered and expertise they provided, which was the same as general practitioners (Donley, 1998a). Midwives also sought to access hospital facilities to safely transfer home births, when necessary. However, achieving these changes required a substantial systemic overhaul.

Women and domiciliary midwives united under a consolidated message, 'Save the Midwives'. Alongside Home Birth Associations, they advocated for informed choices in maternal health, educated their communities, and worked towards better outcomes for both mothers and babies (Banks, 2000).

The grassroots collectives formed by activists played a key role in empowering women through shared knowledge and support. The publicity following the 'Unfortunate Experiment', and then the subsequent Cartwright Inquiry, paved the way to gain momentum as more women became aware of treatments imposed on patients within

institutions. The exposure of these practices resonated deeply with women, many of whom had similar experiences (Coney, 2009). The following sections explore the connection between the rise in activism stemming from the Cartwright Inquiry.

## 2.2 Consumer as Comrade

*Midwives need women; women need midwives.* (Donley, 1986)

Comrade, depending on the context, expresses the meaning of ‘fellow soldier’ or ‘intimate friend’. In terms of the 1980s natural childbirth movement, both could be considered appropriate definitions. The consumers fight (ongoing) against the medical fraternity and the hospital system to achieve an autonomous midwifery-led service model spans 3-decades and is a notable achievement. Braver than soldiers, these women fought against the obstetric system with the written word, not swords. From the inside-out, and the outside-in, they fought collectively for health agency and education, informed consent, and primary birth options.

‘Intimate friend’ describes the sentiment of the natural childbirth community; they attended each other’s births and operated a roster to provide meals for families with a new baby, and groceries or meals for the domiciliary midwives. Midwives and women engaged as partners in health towards a shared goal; a healthy mother, a healthy baby, and an empowering birthing experience (Daellenbach & Edwards, 2010).

The first reported support network of homebirth was a group in Christchurch in 1979. It was in response to hostility from Plunket nurses and hospital employees towards the domiciliary midwife, Ursula Helem (Donley, 1992). Ursula started attending home births in 1974, and the homebirth support group aimed to decrease feelings of isolation for women.

In the 1980s, some of Joan Donley’s home birth women became ‘comrades’ in the childbirth movement. Their convictions were strong, and they identified with the notion Joan outlined in her book, *Birthrights* (1998), that “given support and patience, 85% of women can give birth normally and naturally” (p. 15). There were few domiciliary midwives providing home births in the area and because a doctor’s sign off was also required, natural childbirth was not accessible for many women. Hospital births around that time were considered, by some women, as more than unpleasant

given the strict procedures, unfamiliar staff, routine medications, lack of husband-support, and babies admitted to the nursery so the mother could 'rest' (Abel & Kearns, 1991; Banks, 2007; Dobbie, 1990; French, 2001). These were not welcomed practices by this generation of informed individuals. Consumers and domiciliary midwives learned early on that consciousness raising and politicking was the only way to make change.

The consumers were such an integral part of regaining midwifery autonomy that the framework of the New Zealand midwifery model was based on the collaborative relationship between midwife and woman. This sentiment was coined the Partnership Model (Guilliland & Pairman, 1995), and it became a core tenant of the midwifery profession within New Zealand. The Midwives Handbook of Practice, competency one states, "The midwife works in partnership with the woman/wahine throughout the maternity experience" (College of Midwives, 1993, p. 5). The statement further outlines that the onus is on the midwife to create a functional partnership; and that although the aspects of power fluctuate within the relationship, the woman is in control of her own experience. The marginalisation of the dominant medical profession was a communal feeling (Daellenbach, 1999).

The consumers understood that they needed to raise awareness to gain momentum for the cause. In the early 1980s, when communication channels were through community hall meetings, newspapers, and feminist magazine advertisements, these women began to coordinate with purpose (Daellenbach, 1999). They started their own publication, aptly called, "*Save the Midwives*", facilitated meetings, and advertised within these networks. They formalised The Homebirth Associations (Donley, 1992), while others drew on professional networks (Guilliland & Pairman, 2010). These groups came together for friendship, shared experience, to educate and empower others through their membership to conquer the system.

### 2.2.1 Save the Midwives

*Midwifery, consumerism and feminism, the three greatest threats to modern obstetrics.* (Donley, 1989)

In September 1983, a trio of 'consumers', Joan Donley's homebirth clients, started Save the Midwives (STM). It was a grassroots activist organisation in Auckland in

response to the midwifery staffing crisis and lack of viable options for women that wanted an empowering childbirth experience. Save the Midwives focus was to educate through consciousness raising and improve the quality of their birth experiences. The subscribing membership wanted fewer medicalised procedures in labour because they believed birth was part of a normal stage in reproductive health. They saw midwives as specialists in normal and uncomplicated birth, and were dedicated to championing birth without doctors and increasing the payments for domiciliary midwives.

An empowered birth experience, they argued, would improve breastfeeding rates, decrease postnatal blues, and allow family bonding (Save The Midwives, 1983). Newsletters advertised domiciliary midwives and provided names of the GPs who were supportive of home births. By the second issue, they had a membership of 280 including 50 midwives (Save The Midwives, 1983).

Their policy statement outlined the intentions to promote midwifery as an independent profession, support direct-entry education, and parental rights to information and choice in all aspects of childbirth. They provided information focusing on homebirth and support of the domiciliary midwives, and natural remedies to common ailments such as iron deficiency anaemia, and nappy rash cures for infants. Issues informed of antenatal education classes and exercises to assist when labour. Columns offered sentiments for self-advocating, questions to ask practitioners, and childbirth options for individuals unable to locate a domiciliary midwife or for those requiring a hospital birth. Postnatal groups were advertised, including breastfeeding support meetings (Donley, 1986).

Only the women that were planning a homebirth knew the practitioners that would be attending them labour. However, to have a homebirth, both a domiciliary midwife and a GP who agreed to attend the labour were required. To add complexity, domiciliary midwives were not available across the country (Banks, 2007). In the locations where domiciliary midwives were available, they might be booked or the GP was unavailable.

Due to the low reimbursement for domiciliary midwives, compared with working in a hospital, few were willing (or unable) to undertake the role. Domiciliary midwives earned less financial compensation than an unemployment benefit (Ogonowska-

Coates, 2004). The hourly rate of obstetric nurses in the hospital was far higher than what domiciliary midwives earned. As Lynley McFarland recounted,

*I could only attend a birth if a doctor was overseeing it. I got paid \$25 for attending a birth, that was for six hours of work. The doctor came along to make the cup of tea and take the photos, they used to get \$75. It was the way things were then. (Ogonowska-Coates, 2004, pp. 18-19)*

Banks (2007) related the inequitable pay to “financial oppression” (p. 26) of domiciliary midwives.

Not only were domiciliary midwives paid poorly, but they were also subjected to hostile treatment from hospital practitioners, obstetric nurses, and doctors when transferring a homebirth patient into hospital for treatment. One domiciliary midwife explained how a complaint was laid against her, inciting that she had ‘interfered’ in hospital treatment when she transferred a homebirth client into hospital. Not all hospitals saw domiciliary midwives as adversarial. The Manawatu hospital staff were collegial with the homebirth community, mainly because some midwives worked in the hospital and attended home births (Griffin, 1994).

Although STM had many contributors, it was small but very well-connected group. Marjet Pot and Brenda Hinton (both participants in this research), along with Judi Strid, comprised the core of the STM operation. Although Judi passed away in 2015, she remained actively involved in women’s health rights over the course of her life, as have Marjet and Brenda. They began as a consciousness raising group providing transparent information sharing, which differed from the medical community’s approach of power and control versus information sharing practices at that time (Christison, 2001).

All practicing midwives, including domiciliary midwives, were governed under the New Zealand Nurses Association (NZNA) from 1969. Midwives also had a sub-group called Midwives and Obstetric Nurses Section which represented their separate interests. Members of this group paid their annual membership fees to NZNO but were also charged an additional \$25 per annum towards their sub-membership (Guilliland & Pairman, 2010). The group reportedly felt that NZNO was not appropriately representing their interests. Bev Crombie, midwife supervisor at St Helen’s recounted,

“being accountable to another professional body (doctors) has not taught midwives much about being accountable to a mother, a baby or themselves” (Donley, 1986, p. 7). However, in 1985, after much pressure, the NZNO changed their statement of ‘a midwife as a nurse who...’ and accepted the World Health Organization’s definition as, ‘a midwife is a *person*, who...’. This was considered a huge gain in momentum towards independent midwifery (Donley, 1998a).

The STM newsletters informed its membership of decisions made by the hospital boards. They also requested that members write letters to hospital managers, providing addresses and outlining the points of concern to be included in the correspondence. When Auckland hospital board proposed the closure of five small primary birthing units—Helensville, Howick, Papakura, Warkworth, and St Helen’s (Save The Midwives, Spring, 1984)—the strong community pressure allowed two of the units to remain open. As anticipated, the closures of the units pushed women into main tertiary hospitals where high numbers of public patients were made available for medical student training (Dobbie, 1990) rather than having midwives or GPs available to attend births (Save The Midwives, Winter, 1984).

To maximise the group’s work on health reform and patient advocacy, information was advertised across similar profiled groups. Save the Midwives flagged communications to Sandra Coney, a founder of the nationwide feminist magazine, *Broadsheet*. In one issue, Brenda Hinton advertised a survey on childbirth indicating that the collated results would be sent to hospital boards to promote change (Hinton, 1987). The collective action of these women did not go unnoticed. Outside New Zealand, an expatriate living in New York wrote into *Broadsheet* to praise Joan Donley, Lynda Williams, Sandra Coney, and Philinda Bunkle for their devoted work towards women’s health (Young, 1990).

Save the Midwives compared New Zealand maternity to countries where the maternity model was succeeding. Germany and The Netherlands reported a strong commitment to natural childbirth and maintained good outcomes (Larkin, 1984b). The featured advantages of a continuity of midwife model were greater levels of maternal satisfaction and improvements in foetal and maternal mortality statistics. For

midwives, their sights were set on a living wage, increased job satisfaction, and stronger overall community involvement, all with the benefit of a less costly service.

### 2.2.2 The Unfortunate Experiment and the Cartwright Inquiry

Sandra Coney and Phillida Bunkle's article, published in Auckland's Metro magazine, served as the catalyst for the Cartwright Inquiry into the practices at National Women's Hospital and the University of Auckland (Coney & Bunkle, 1987). The article was prompted by a colleague at the University of Auckland's medical school, who had alerted Coney and Bunkle to journal publications documenting unethical cervical cancer research conducted at Auckland Hospital between 1962 and 1974, led by Dr Herbert Green. The inquiry led to Professor Denis Bonham, the head of obstetrics at the University of Auckland, being charged with four counts of 'disgraceful conduct' for his role in approving Dr Green's research (Jones, 2017). Bonham was instrumental in all the closures of the primary maternity units, which essentially consolidated births in teaching hospitals.

Several articles published during and after the Cartwright Inquiry revealed that the patients were diagnosed with cervical cancer at National Women's Hospital, but they were not offered standard care or appropriate treatment. Instead, Dr Green observed the women's health deteriorate over time while their cancers continued to grow. Besides not offering treatment over this extended period, he did not inform them of their condition. Many of the women required hysterectomies while other women died (Coney, 1988). Simultaneously, female infants that were born in the hospital had their cervixes swabbed and tested for cervical cancer cells without parental consent (Cartwright, 1988).

The full extent of Dr Green's misconduct only came to light because of the inquiry. Additionally, it was uncovered that as part of their training, University of Auckland medical students were performing rectal and vaginal exams on anaesthetised women without their consent. Part of Green's research involved collecting vaginal swabs from 2,244 female newborns, aged between 24 hours and 5-days, without parental consent. Green had theorised that women were born with cervical cancer. Although he did not perform the infant cervical swabbing, he delegated this procedure to the maternity nurses who were known as 'Special Duty Sisters' (Coney, 1988). After he analysed the

first 200 neonatal swabs, Green's hypothesis was disproved; however, the swabbing continued and further 2,000 newborn girls were subjected to a vaginal exam and their cervix prodded. A cessation of the practice was not communicated to the nursing staff, and the continued collection of cervical smears were discarded (Cartwright, 1988).

Furthermore, during the inquiry a box in a clerical office at National Women's Hospital was discovered containing "sections of whole baby uteri set in wax" (Cartwright, 1988, p. 141), these were obtained from stillborn girls, without parental permission. The scale of the abuse and the systemic disregard for patient consent and ethical medical practices became increasingly evident throughout the inquiry. A sustained pattern emerged of inappropriate medical power being wielded over women and newborn girls for more than 20-years. The findings of the inquiry shocked the public and prompted a wider investigation into medical teaching practices across other institutions.

The medical profession's response to the Cartwright inquiry was to shift the blame onto patients (Cartwright, 1988). Women were criticised for not asking enough questions and were further blamed for having unrealistic expectations of a public hospital (Coney, 1993). During the inquiry, Dr Gabrielle Collison, the Superintendent of National Women's Hospital, claimed that consent was not explicitly sought as it was assumed that women were aware that they were in a teaching hospital (Coney, 1988). In addition, practitioners attempted to deflect responsibility by accusing the 'feminists' who exposed the experiment as initiating a 'witch hunt' (Coney, 1995). Concern was voiced within the medical community that the inquiry would erode public trust in doctors and the healthcare system. It was a missed opportunity for the profession to reflect on the power imbalances that had enabled such practices.

This period marked a crucial shift. The inquiry became a catalyst for change, challenging the medical establishment's patriarchal authority and prompting a wider societal reckoning. It exposed the institutionalised power dynamics that undermined women's agency, supporting the movement of women's empowerment and advocating for the midwifery partnership model. By questioning the practices within powerful institutions such as universities and hospitals, the inquiry illuminated the

need for systemic change, which ultimately paved the way for a more collaborative approach to maternity services.

In the inquiry's aftermath, there was a notable surge in public support for the natural childbirth movement. Women increasingly reclaimed control over their personal health decisions (Guilliland & Pairman, 2010). This shift in autonomy also propelled the movement for independent midwifery, which gained significant momentum as traditional, medicalised approaches to childbirth were scrutinised (Banks, 2007; Donley, 1986). For the first time, women began actively resisting the fragmented nature of maternity services, demanding greater continuity of care and wanting to know who would be responsible for them throughout the childbirth continuum. They sought increased involvement in decision-making, asserting their right to shape their own birth experiences (Daellenbach, 1999; Guilliland & Pairman, 2010).

The 1989 Cartwright inquiry, led by Judge Silvia Cartwright, marked a pivotal moment in challenging deeply ingrained beliefs, such as 'doctor knows best', in the context of women's health. The inquiry's findings were particularly significant following the revelation of 'disgraceful conduct' charges against Professor Denis Bonham. The inquiry led to a public distancing of the hospital from Bonham's approach to childbirth, notably his role in reinforcing medical control over women's reproductive choices (Coney, 1988). Cartwright's ruling provided a crucial boost to consumer health advocates, validating their calls for a more patient-centred health system.

Recommendations from the inquiry proposed changes to medical research and ethical practices and implemented required consumer involvement in the healthcare system (Bunkle, 2010). Among the key outcomes was the appointment of Lynda Williams and Judi Strid, prominent women's health advocates, as the first lay members on hospital boards. Strid also contributed significantly to midwifery education, becoming a member of the Direct-entry Taskforce (1990) and continued her work as a consumer advocate, supporting midwifery reform for many years (De Vore, 1995).

### 2.2.3 Home Birth Association

Save the midwives and the home birth associations learned that New Zealand was not the only country experiencing a renewed interest in the natural childbirth movement during this period. Scandinavian nations and other European countries, such as the

Netherlands, had long adopted a midwifery model that included access to home births. Similarly, women in the UK, the United States (US), and Canada began to express a growing political interest in regaining control over their own health and childbirth choices (Goldman, 1988).

In the US, this shift was closely intertwined with broader social movements, including the counterculture hippie movement and the Black Panther Party, both of which developed alongside protesting America's involvement in the Vietnam War (Kline, 2015). These movements reflected a deepening distrust of the government, which was expressed both through political activism and cultural events like the iconic Woodstock music festival. At the same time, the rise of feminism and the increasing popularity of books such as *Our Bodies Ourselves* (Boston Women's Health Book Collective, 1976) empowered women to take charge of their personal health through education and the sharing of knowledge, further fuelling the demand for more autonomy in health, including childbirth.

The 1970s marked a generational shift in which young people began to reject the traditional authority structures of the previous generation, embodied in slogans such as 'Stick it to The Man' or in the local New Zealand feminist magazine, *Broadsheet*, in circulation between 1972 and 1997 (Schrader, 2014), a regular column entitled, 'Kicking against the Pricks' written by Sandra Coney (1972) the magazine's editor.

This era was characterised by a widespread awakening of consciousness, with a focus on expanding the mind; embracing Eastern philosophies and spiritual practices; and adopting alternative lifestyles, including vegetarianism, freedom, and recreational drug use. The counterculture movement, encapsulated by the 'make love, not war' ethos of the hippie generation, naturally gave rise to a resurgence in both natural living and active childbirth (Kline & Kline, 2019).

During this time, there was growing interest in literature advocating for natural childbirth, such as *The Bradley Method* in 1965 (Wallace, 2000) and *Spiritual Midwifery* (Gaskin, 1977). In contrast, Suzanne Arms' (1975), *Immaculate Deception*, critically examined the medical system, identifying it as a key driver of the increasing medicalisation of childbirth, and drew parallels between hospital procedures and the dehumanising conditions of industrial factories. Globally, there was a widespread

rejection of established doctrines, a trend that extended to New Zealand. The ideals of the hippie movement took root in New Zealand where communes, influenced by the design principles of the Israeli kibbutz, began to sprout across the country (Jones, 2023). This cultural migration played a significant role in shaping New Zealand's own version of the natural childbirth movement, echoing the broader international trend towards rejecting the traditional institutionalised systems. This cultural shift, both globally and locally, became a powerful catalyst for the natural childbirth and home birth movements, challenging the prevailing norms and providing a fertile ground for the development of midwifery models that prioritised women's personal agency of their childbirth experiences.

The natural childbirth movement gained significant momentum, in part due to the recirculation of key works by French obstetricians. Fernand Lamaze's pioneering breathing techniques, drawing on conditioning responses popularised by Pavlov, became widely embraced in the 1960s (Michaels, 2010). A decade later, Frédéric Leboyer (1974), another French obstetrician, published *Birth Without Violence*, and focused on the neonatal transition from the womb to the outside world. His work advocated for water birth, emphasising gentle, less invasive approaches to labour and birth. Similarly, Michele Odent, a staunch proponent of non-medicated childbirth, explored the physiological condition of the neonate in his influential texts *Bien naître* (1976), meaning 'to be born well', and *Birth Reborn* (1984). These works further cemented the natural childbirth movement's focus on physiological birth and the well-being of both mother and child. Around the same time, Marsden Wagner, an American perinatologist and perinatal epidemiologist, promoted the benefits of natural childbirth through his research on the diverse childbirth practices across Europe, particularly during his tenure at the World Health Organization.

In the UK, obstetrician Grantly Dick-Reid and anthropologist Sheila Kitzinger became central to the movement. Dick-Reid's *Childbirth Without Fear* (1959) was initially met with ridicule by his medical colleagues upon its publication but, over time, it gained widespread acceptance, especially among the next generation of women (Caton, 1996). Kitzinger (1978, 1979), with her anthropological lens, contributed significantly to the understanding of birth as a cultural and emotional experience, advocating for attachment parenting and exploring birth and bonding rituals from around the world.

These authors, alongside their contemporaries, played a pivotal role in shaping the discourse surrounding natural childbirth, and contributed to a shift in societal attitudes towards woman-centred and physiological approaches to childbirth.

In New Zealand, Joan Donley's *Herstory of N.Z.* (1992) provides a historical account of the local home birth movement and the work of domiciliary midwives. Across the country, Home Birth Associations emerged, primarily in larger regions such as Auckland, Christchurch, Dunedin, Tauranga, Manawatū, Waikato, Wellington, and Southland (Daellenbach, 1999). While the strength and influence of these groups varied, certain factors contributed to their success, most notably access to both a domiciliary midwife and a supportive GP.

As stipulated by law, domiciliary midwives were required to have a doctor present at a birth, which posed a barrier for some women who were unable to secure a willing GP (Abel & Kearns, 1991). In some regions, it was understood that a GP might attend the birth upon the midwife's request (Banks, 2007); while in other instances, GPs opted to sign off on the birth later, only to ensure they received the payment (Daellenbach, 1999). These regulatory and logistical challenges highlight the complexities in meeting the legal requirements.

The Manawatū Home Birth Association (MHBA) emerged as one of the most influential and successful groups in New Zealand for several key reasons (Daellenbach, 1999). Strategically located, just a 3-hour drive from the nation's capital, Wellington, Manawatū offers both suburban and rural terrain. The city itself is of a size that fosters a close-knit, community feel, with long-standing familial ties across sectors such as education, sports, and government, and these elements combined facilitates easy access to information and services (Christison, 2001). Meetings were often held in member's homes, before the MHBA secured a large villa as its headquarters. This grassroots approach enabled the group to maintain a strong local presence and foster a sense of belonging within the community.

Outside of the Manawatū, domiciliary midwives who needed to transfer women into hospital care often reported unprofessional and non-collegial treatment by hospital staff (Ogonowska-Coates, 2004). In contrast, in the Manawatū, the community was quite different. As domiciliary midwifery was not a highly lucrative profession,

midwives balance home births with hospital shifts. This dual role allowed them to maintain a visible presence within the hospital system and, because they were 'known' to the hospital staff, they often received a degree of support; although at times it was more a grudging tolerance, depending on the domiciliary midwives' relationships with colleagues (Griffin, 1994). This close connection between the domiciliary midwives and hospital staff helped to mitigate tensions when transferring home birth clients into hospital care and contributed to a successful and sustainable work of the MHBA in the region.

In Auckland, although there were many GPs, a significant number were unwilling to support home birth, often associating it with the 'radical fringe' (Fleming, 1996). The justification that midwives needed to knock on doors and advise the public were cited as additional parking requirements, although the requirements would be similar for a GP practice, dentist, or even for a hair salon, and they did not require obtaining the neighbour's permission.

The consumers organised Homebirth Association conferences which provided opportunity to connect and continue to strategize. Bronwen, a research participant, talked about the mood in the room and the sentiment of where midwives and women were steering towards. The Save the Midwives surveyed GPs to assess their willingness in collaborating with domiciliary midwives, revealing that support was more widespread than previously thought (Strid, 1987). Yet, the 1980s were a time when hospitals held a considerable amount of power and discretion to refuse access to services. Many doctors hesitated in supporting home births due to fear of losing the lucrative income from hospital births (Fleming, 1996). These institutional barriers and professional reluctance from some doctors created a challenging environment for midwives and the consumers.

The HBA played a crucial role in consumer involvement and empowered families within their communities. Through collaborative relationships between midwives and consumers, the Domiciliary Midwifery Standards Review was developed. Initially an effort to ensure high-quality care in home birth settings, the review was later adopted by the College as part of their professional standards for practice (Daellenbach, 1999). By formalising standards, the HBA helped establish a cohesive and professional

approach to domiciliary midwifery and contributed to the long-term midwifery practice of reflection and consumer engagement.

The Cartwright Inquiry, coupled with the global rise of feminist movements, catalysed a shift in women's attitudes towards the previously accepted medical practices. Women began to question the fragmented services, who would be with them at the time of birth and throughout their entire labour journey (Christison, 2001; Griffin, 1994). The desire for continuity of care reflected a broader demand for decision-making power and a greater sense of control over their birthing experience (Ogonowska-Coates, 2004). For many, the only viable way to achieve their desired goal was through home birth, where they could work with practitioners who supported their values and allowed their voice to be present in their birth experience.

This desire for control and independence was central to the broader movement for reform in childbirth practices. The next section focuses on the evolving role of midwives and the growing recognition of their expertise in maternity.

### 2.3 Midwifery Standards Review

Consumers from the Auckland HBA were closely aligned with The Domiciliary Midwives Society. In the community, domiciliary midwives were governed by their local Department of Health and were overseen by the principal public health nurse. In 1988, Auckland National Women's Hospital's obstetric team began pressuring the public health department to monitor and evaluate domiciliary midwives' practices. Originally, the plan was based on the medical model; however, the Domiciliary Midwives Society created their own monitoring as a strategy, one of resistance (De Vore, 1995). This was largely created by the consumers, developing a mechanism of support for midwives who were working on their own (Donley, 1993). The process was largely considered consumer peer review (Daellenbach, 1999). As more midwives began practicing over the next few years, HBAs across the country adopted standards review committees (Donley, 1992) which were used by domiciliary midwives who practiced independently as a mechanism to share knowledge, reflect and improve their practice (Banks, 2007).

The principal public health nurse in Auckland was supportive of midwives, and the review panel was made up of two consumers and two midwives. Panel discussions

included aspects affecting practice such as which GPs or hospital staff were supportive, who to avoid, where to purchase equipment, what it would cost, and what might be a useful instrument for a birth kit.

In 1993 the New Zealand College of Midwives (NZCOM) was established, and the Midwifery Standards Review process was absorbed under their domain (Daellenbach, 1999). As hospital midwives came out to work in the community, many were not familiar with the Home Birth Associations and did not understand the commitment and dedication of consumers' commitment to progressing the Amendment Act to pass. As early as 1994, a distinct difference was noted during the Standards Review panels across midwifery practices (Banks, 2007) and although consumer support was strong, and some consumers travelled the country holding workshops for newly minted panel lay members; over time as midwifery became more professionalised, the connection between midwives and consumers began to wane. Consumers began to lose interest in attending College meetings, citing that meetings were too political, or they felt that their input was not considered valid (Daellenbach, 1999). The review process used by registered midwives in 2025, was developed in part by Bronwen, Sian, and consumers Brenda and Marjet.

By 1999, the independent midwives were servicing nearly 70% of the birthing population; however, intervention rates continued to rise (Banks, 2007). The midwives who had previously worked in the hospital did not adopt the partnership model with their women and did not understand why a consumer would be on a professional standards review panel. Some resented consumers questioning their practice, which they took as criticism.

The College developed the midwifery profession through frameworks; standards and codes for practice, referral guidelines, and so on. One midwife outlined this phase as going "from trust to accountability, from friendship to respect, and from gratitude to expectation" (Skinner, 2023, p. 94) when outlining the shift after The Act passed and midwifery became a recognised profession. This process created a divide in the relationship between midwife and consumer. The non-hierarchical structure of the Standards Review process was created by consumers and domiciliary midwives, who together decided what constituted good midwifery practice (De Vore, 1995). It was

based on the midwifery-led model of care which centred women in genuine partnership.

## 2.4 The New Zealand College of Midwives (NZCOM)

The discussion to leave the New Zealand Nurses Association (NZNA) to join a separate midwifery professional organisation had continued over many years. Joan Donley's (1988) presentation at the National Midwives Conference, *Midwives or Moas?*, challenged midwives to either stand up for their profession or to become extinct. The presentation set the tone for the conference and the mood prompted Karen Guilliland, the first president of NZCOM, to call for midwives to separate from the NZNA once and for all. A swell of enthusiasm filled the room, both midwives and consumers knew that for a separate organisation to be successful, they needed each other (Guilliland & Pairman, 2010).

The NZNA contended that a sub-group of midwives allowed obstetric nurses and midwives to specialise in different areas of care, while the special interest midwives section of the NZNA argued that remaining under nurses caused midwives to lose the knowledge and skills (Donley, 1986). In 1972, when the International Confederation of Midwives (ICM) defined a midwifery scope of practice as autonomous, midwives in New Zealand were keen to adopt this definition in practice (Guilliland & Pairman, 2010). However, joining the ICM was not seamless. New Zealand wanted consumers to be acknowledged, and, although it took time, the ICM finally agreed.

In an amendment to the Nurses Act, 1983, the NZNA further restricted midwifery practice by prohibiting individuals who were not also nurses from attending births outside a hospital. Exceptions were granted to direct-entry domiciliary midwives as they were being 'supervised' by the principal public health nurse, through the local public health board (Christison, 2001). Additionally, The Act allowed registered nurses to supervise obstetric nursing which further minimised midwives' skills. Consumers argued this practice perpetuated the medical model (Hinton & Pot, 1984).

The NZNA members of the 'midwives special interest section' did not have a large enough voting group to gain traction to prevent change against NZNA policies (Guilliland & Pairman, 2010). Midwives also wished to partner with women,

implementing the idea from te Tiriti (Daellenbach & Thorpe 2007) to effectively flatten the hierarchical structure entrenched in the medical culture. As nursing had historically been regulated by the medical society, nurses resented the notion of midwifery autonomy (Papps & Olssen, 1997).

For midwives, the notion of pregnancy, labour, and birth was philosophically understood as a normal reproductive life event (Donley, 1986). Most births were happening in the hospital mainly because the primary maternity hospitals closed (Tew, 1995). Through the fragmentation of maternity services in New Zealand, midwives were subsumed under nursing and, therefore, were not facilitating childbirth as a life event (Donley, 1988).

Establishing the College intended to disrupt the medicalised view and recreate structures where women and midwives together could promote empowering childbirth experiences (Guilliland & Pairman, 2010). The College also intended to bring domiciliary and hospital midwives together under one governing structure and represent their shared interests. The College solidified the midwife-led, partnership model for all midwives and consumers (Fleming, 1996).

The first official College meeting was on September 3, 1988; although it took several years for the profession to accept core principles around continuity of care and partnership with women (Skinner, 2023). To unify midwives, a targeted campaign was developed entitled, 'A midwife is a midwife is a midwife' (Guilliland & Pairman, 2010). By 1995, the College represented approximately 300 independent midwives as registered practitioners (Fleming, 1995).

While the College continued to gain momentum for the whole of the profession, it was confronted with strong resistance and attacks from medical 'colleagues.' The next section outlines tactics employed by the medical community to intentionally obstruct primary birth and midwifery by the medical professions.

## 2.5 The Medical Fraternity and the Fight to Retain Power and Control

*It is clear from the international experience that the very best maternity care situation is when midwives with their social approach are solely responsible for the 70-80% of women who have normal pregnancy and birth, and obstetricians are hospital-based specialists*

*used exclusively for complicated pregnancies and births. This then would require the combining of these two different movements and there is a great deal of resistance to change in maternity services. This is not hard to understand since at the present time the maternity care system are essentially completely under the control of the medical profession and consequently this profession is not likely voluntarily to give up this power and this control. Thus, to keep their control the medical profession must control the midwifery profession and there is today an ongoing worldwide attempt by the medical profession to suppress the profession of midwifery. In every country a different battle is taking place and all of it is part of a 20th century witch -hunt because men are afraid of the power of women and this fear is nowhere better seen than with regard to midwifery. (Marsden Wagner, 1990, p. 13)*

Marsden Wagner, internationally regarded perinatal epidemiologist, Director for Women's and Children's Health for the World Health Organization, spoke the above words in Dunedin at a NZCOM conference. He discussed the high levels of medically managed childbirth in New Zealand, compared with the rest of the world. Wagner (1990) noted that the local forceps rate of 14%, was double that of European countries, and directly related to the surprisingly high 40% epidural rate. Further, he expressed that New Zealand was misusing forceps when the ventouse, a lesser damaging instrument, would suffice.

This section outlines the actions by the New Zealand Medical Association (NZMA) to attempt to eradicate midwifery autonomy to retain control of maternity service funding. Discussed in this section are the deliberate stonewalling methods the medical fraternity used to undermine the plight of the natural childbirth movement immediately prior to The 1990 Act. The NZMA refused hospital access to midwives, gatekept information, and used fear mongering to discredit midwives. Although midwives continue to this day to be exposed to medical antagonism at varying degrees, this section focuses on historical records.

Prior to The 1990 Amendment Act, hospital midwives managed a patient's labour until birth was imminent, then they called a doctor (Skiff, 2014; Skinner, 2023). Home birth was similar, a domiciliary midwife attended labour and then rang the GP at the point of delivery, or afterwards (Ogonowska-Coates, 2004), depending on the relationship the midwife had with the GP, or the mother's request (Banks, 2007). While midwives

reportedly had good working relationships with doctors, more generally their role was as a subordinate.

Medical superintendents and hospital-based midwives continued their antagonistic treatment to domiciliary midwives when transferring home births into hospital. Individual midwives were met with confrontations such as informal or formal complaints, or intimidation in hospital settings (Donley, 1998a). Often women who were transferred into hospital from a home birth were exposed to personnel slandering their midwife (Fleming, 1995).

Although the GPs supportive of home birth continued to work alongside midwives in a collegial way (Griffin, 1994), other doctors withheld midwifery referrals when a patient presented with a confirmation of pregnancy (Davis, 1995). Some doctors employed midwives in their practice to offer a general maternity service. If they did refer a patient to a midwife, it was largely because the patient was considered too 'difficult' (Fleming, 1995).

Within hospitals, the obstetric teams and clinical managers facilitated access agreements for practitioners. When the 1990 Amendment Act was passed, instead of providing access to midwives, many hospitals were intentionally obstructive. Hospital medical directors, mainly male doctors, stonewalled midwives by denying hospital privileges. The hospital directors would decline or skive previously agreed meetings (Firkin, 2004). Independent midwives could take hospitals to court citing the Commerce Act; however, the lengthy court proceedings were financially draining. Hospital lawyers also used procrastination techniques and would file motions for continuances sometimes taking up to 24 months before cases were heard (Firkin, 2004). Having little alternative options, and at great expense, NZCOM hired lawyers to interpret the laws to progress for access.

The medical society used the media to damage the professional reputation of midwives. Laying a professional complaint against a practitioner would be used to pique media interest regardless of if the midwife was at fault (Banks, 2007), often being taken as fact despite many details being untrue. Directly contacting the media after a bad outcome of a home birth transfer was another manoeuvre used by hospital staff (Christison, 2001; Daellenbach & Thorpe, 2007; Skinner, 2005). Independent

midwives were under heavy scrutiny controlled by the medical fraternity and hospital staff (Moloney, 1992). Midwives began to practice more medically to appear as working in an 'approved' manner to avoid public reprimand (DeVore, 1995; Donley, 1992) increasing the medical interventions performed by midwives (Moloney, 1992).

The NZMA interfered in financial contracting negotiations between the College and the Ministry of Health; inveighing midwives' scope should be restricted to 'low risk' pregnancies. At the same time, they were deliberately attempting to expand the definition of pregnancy 'risk' to include nearly all pregnancies (Daellenbach, 1999; Skinner, 2005). The purpose of employing this tactic was both to control women and midwives. Prior to the College formation, the NZNA special interest midwives' section had been working alongside the Department of Health to determine the parameters of low-risk pregnancy (Daellenbach, 1999). Unable to evade defining pregnancy 'risk' status, the College modified and adopted a version in the founding documents for midwifery practice in 1989 (Guilliland & Pairman, 2010).

Obstetricians refused to cooperate with midwives as colleagues, putting the onus on midwives to bend when making referrals (De Vore, 1995). Often when a midwife referred a patient for an obstetric consult, which was in their guidelines to do so, the patient would not return to the midwife's care (Skinner, 2005). Obstetricians prevented midwives and women from accessing accurate information and hospital services. When these actions did not have the expected impact, NZMA used media outlets to echo their message at a national scale. The 1990 Amendment Act meant equal pay for equal work; however, the NZMA's reaction was unprofessional and vindictive.

In summary, this chapter has outlined the beginnings of the grassroots natural childbirth movement; the midwife and consumer partnership; and how, in partnership, they formed the structures for midwifery professional-peer review. Together they also developed both the HBAs and NZCOM. Finally, they solidified consumers in-partnership within midwifery standards of practice nationally and internationally, with the ICM. However, as soon as midwives and consumers developed these structures, the obstetric community began their attempts to dismantle their partnership. The next chapter presents a narrative review of the literature.

## Chapter 3 Narrative Review of the Relevant Literature

The previous chapter established extensive context for this thesis. The current chapter provides a narrative review of the literature specifically focused on what has been written about the Nurses Amendment Act 1990, essentially in relation to midwifery, maternity services, and the professionalisation of midwives in New Zealand. The central question guiding this review is: *What is known from the existing literature about the Nurses Amendment Act, 1990?* It is important to identify what has been written about the Act, to rule out that this research had not already been performed. Additionally, it is helpful to know what has been published about the Act, because this can provide insight into what knowledge had been circulating about maternity services.

The Nurses Amendment Act 1990 marked a significant reform in New Zealand's maternity services by establishing a legal framework for the midwifery profession. For pregnant women, The Act facilitated choices in selecting practitioners and choosing the location for birth. For midwives, The Act ensured adequate financial reimbursement and granted them the autonomy to provide maternity services; previously, only doctors with obstetric certification were entitled to claim payments for these services. This pivotal change redefined midwifery practice and had profound implications for the power dynamics between midwives, the medical profession, and women accessing primary birthing options at home.

### 3.1 Methodology for the Narrative Review

This narrative review employs a systematic approach to identify the available literature (Green, Johnson, & Adams, 2006). The designated selection of relevant sources was guided by criteria set out by Paré and Kitsiou (2017) outlining that the researcher identifies which studies to include, and in this instance I focused on studies related to the midwifery profession, maternity services, and childbirth, particularly those addressing the impact of The Nurses Amendment Act 1990. The search aimed to capture a comprehensive range of perspectives, encompassing academic articles, postgraduate theses, and grey literature, such as governmental reports and publications from the Joan Donley Midwifery Research Collaboration (JDMRC), a

database designed as the evidence arm of the New Zealand College of Midwives, to identify what research has been undertaken in the 'local' maternity context and by whom.

## 3.2 Search Strategy

The search was undertaken in 2024 and designed around the question: *What is known from the existing literature about the Nurses Amendment Act, 1990?* To refine the search, I developed specific inclusion and exclusion criteria to guide the process, as outlined below.

### 3.2.1 Inclusion criteria

- Sources that focused on midwifery, midwives, maternity services, and childbirth; particularly those discussing events leading up to or immediately following enactment of the 1990 Act.
- Sources examining the role of key individuals who were instrumental in advocating for and implementing the Act.
- Sources exploring the experiences of midwives or consumers of maternity services leading up to 1990.

### Exclusion criteria

- Sources focusing on nursing or non-midwifery professions that did not directly relate to the Act.
- Sources which make mention of the Act in justification for independent midwifery as it relates to their specific research; for example, aspects of midwifery practice (i.e., mentoring, education or rural midwifery), unless these topics were specifically linked to the Nurses Amendment Act 1990.
- Articles discussing broader public health reforms without connecting them directly to the legislative changes or the individuals involved in the process.

## 3.3 Study Selection

The initial search using the phrase 'Nurses Amendment Act 1990' yielded limited results, with a noticeable gap in literature specifically addressing the key individuals involved in The Act's development. While several sources did mention The Act, most merely discussed its implications for midwives' autonomy without exploring the

deeper historical or political context leading to the reform. Searches performed in the databases EBSCO and CINAHL did not yield results.

Using the same search phrase in Google Scholar, 104 results were retrieved. Data filters were not applied, although duplicates were removed from this total. Many sources were excluded as they cited the Act in order to reference core tenets of local midwifery professional trademarks; partnership, autonomy, and decision making in practice; rather than to discuss experiences of midwives. For example, one recent source targeting practicing midwives, Parker et al. (2024) advises midwives to create space for diversity and LGBTIQ+ whānau-centred approaches stating, “The Nurses Amendment Act 1990 established midwifery as an autonomous profession, publicly funded to lead community-based care for whānau from early pregnancy to the early” (p. 1). Other articles related to rural midwives, sustainable practices, media discourses, wāhine Māori birth experiences, equity issues in healthcare, and cultural safety practices. The 11 sources from Google Scholar of relevance to this thesis had already been referred to in Chapter 2 (Abel & Kearns, 1991; Banks, 2007; Coney, 1997; Dallenbach, 1999; Fleming, 1996; Griffin, 1994; Grigg & Tracy, 2013; Hendry, 2003; Lennox, 2002; Pairman, 2005; Papps & Olssen, 1997).

For this narrative literature review, results were also sourced from The Joan Donley Midwifery Research Collaboration (JDMRC). The search term, ‘Nurses Amendment Act 1990’, excluded a comma before 1990, did not include ‘The’, and quotation marks were not applied. Fourteen papers were identified, six of which were deemed relevant. All abstracts were read, with five meeting the inclusion criteria.

### 3.4 Collating, Summarising, and Reporting the Results

In searching for sources, or data, a simple quantitative count of the number of articles has been previously articulated. The next steps involved collating, summarising, and reporting the results. These are described below. Generally, it meant organising sources into broad categories for an overview to discern what should be reviewed, based on inclusion and exclusion criteria. These broad categories allowed me to organize and make sense of the data. Grouping similar research ideas together provided me with a mechanism to more articulate the ‘results’ of the search.

### 3.4.1 Collating

Although 14 items were found in the JDMRC, nine were excluded as they related to the College of Midwives annual reporting, duplicated conference proceedings, or midwifery education. A further four were excluded because they did not meet the inclusion criteria and did not relate to the question. The remaining five were reviewed.

### 3.4.2 Summarising

The five articles collectively chart the shift in New Zealand midwifery following the 1990 Nurses Amendment Act, capturing both the momentum and the aftermath of professional autonomy. Hendry (2001) provided a historical overview of the socio-political conditions which offered midwives legislative opportunity, while Coco (1993) situated this change within broader inter-professional tensions, highlighting the unease it provoked among GPs accustomed to dominance in maternity services. Pairman (1999) reflected on the philosophical repositioning for midwives which accompanied autonomy, particularly partnership with women which has foundations within the profession's emerging identity. However, Woodley (1994) noted that despite legislative gains, midwives' relationships with each other were strained, with fragmentation undermining the professional solidarity that was required of the childbirth movement. Rolston (1999) noted that with autonomy came empowerment but also emotional toll and professional burdens through which independent midwives navigated burnout and compassion fatigue from demanding practices.

### 3.4.3 Reporting the Results

Three broad categories were evident within these sources. Historical and legislative autonomy; identity, philosophy, and partnership; and challenged within practice autonomy. These categories are elaborated below.

#### 3.4.3.1 Historical and Legislative Context of Autonomy

Hendry (2001) and Coco (1993) establish the socio-political groundwork and the legal shifts which enabled midwifery to regain independence. Hendry focuses on the socio-political factors which enabled midwifery autonomy; outlining the profession in the late 1980s and early 1990s. Hendry identified the foundational context of legislative change and political momentum; while Coco addressed medical professional's

reactions to the Nurses Amendment Act and the impact on interprofessional dynamics. Although Coco's article supports Hendry's account, the focus is on external resistance of the medical resistance to the financial loss of competing with midwives for maternity services.

#### 3.4.3.2 Identity, Philosophy, and Partnership

Pairman (1999) and Woodley (1994) explore the ideological and philosophical repositioning of midwifery, particularly in educating around the professional concept of partnership. Pairman highlighted the development of midwifery identity through partnership with women and articulated the role of NZCOM to support these values. Woodley identified internal relational challenges that were evident a few years after the legislation change. The article defines a partnership model included partnering with women and identified the need of unification among midwives.

#### 3.4.3.3 Challenges of Practising Autonomy

Rolston (1999) dealt with the emotional toll and professional pressures resulting from new expectations under autonomy. The focus of the source is on burnout and compassion fatigue, and the emotional and professional challenges for independent midwives.

#### 3.4.4 Discussion of Findings

The literature demonstrates that the Nurses Amendment Act, 1990 was a transformative piece of legislation that fundamentally altered the landscape of maternity care in New Zealand. The Act enacted midwifery autonomy, improved financial reimbursement for midwives, and provided greater choice for women in selecting their maternity caregivers. However, the implementation of the Act has been marked by ongoing challenges related to power dynamics between midwives and obstetricians, and has influenced more contemporary issues such as burnout.

Lack of detailed research into the key figures responsible for the Act, and the experiences of midwives during the reform period, suggests that there are important aspects of the Act's history that remain under-explored. The limited research on the long-term effects of the Act also points to a significant gap in the literature.

### 3.5 Conclusion

Most of the sources found were relevant to New Zealand midwifery context which means that their research was only possible because of the participants from this research, and a few other individuals who were responsible for the Act. However, despite the impact the Act has had on maternity services and midwifery within New Zealand, it is astonishing how little evidence can be found relevant to the wider research inquiry. However, it provides a strong justification for the current research which garners these individuals' perspectives who, along with Helen Clark, shepherded the Act into law, and went on to create the professional structures which maintained the midwifery profession. The previous chapter focused on the socio-political and cultural context; this chapter has presented a focused narrative review of the Act itself. Both chapters provide a nuanced appreciation of the setting for this thesis. The next two chapters present the research methodology and methods.

## Chapter 4 Methodology

This chapter introduces the theoretical positioning and methodological approach underpinning the study. I begin by presenting my ontological position, grounded in critical realism. I then discuss my epistemological stance, which draws from both social constructionism and critical feminism. Together, these research paradigms inform and shape my research approach.

### 4.1 Theoretical Framework

Using a narrative methodology and methods, this study examines the narratives of midwives and maternity health consumers who played a pivotal role in securing midwives' right to independent practice, separated from nursing and medical oversight. These individuals subsequently contributed to the development and advancement of the midwifery profession in New Zealand. The nature of the knowledge gained from these narrative interviews was understood within a critical realist ontology and a social constructionist and critical feminist epistemology.

### 4.2 Ontology: Critical Realism

Ontology, which concerns the nature of reality, shapes a researcher's approach to knowledge production (Crotty, 1998; Kivunja & Kuyini, 2017). It seeks to address the fundamental question, 'What is reality?' and guides how meaning is derived from research data.

The research paradigms of relativism and realism view reality through different lenses. Realism proposes a separate world 'out there' that is not reliant on how individuals construct it (Burr, 2015; Nightingale & Cromby, 2002); thereby presupposing that the world can be explained and understood as a 'fixed' structure in an objective way. Thus, reality is reduced to a single truth (Burr & Dick, 2017). By contrast, relativism, which is doubtful of a single explanation to one way of knowing, argues that how individuals come to understand reality is subjective (Nightingale & Cromby, 2002) and because of the subjectivity, understanding can shift over time.

This study adopts a critical realist ontological perspective. Critical realism embraces aspects of both relativism and realism. While realism posits an objective reality

accessible only through research (Braun & Clarke, 2013), critical realism acknowledges that individual perspectives shape understandings of that reality. Critical realism thus combines a realist ontology, there is something real to discover, with a relativistic epistemology, recognising that different people may come to know different things in different ways. This dual perspective allows for a deeper exploration into how the objective structures and subjective experiences can interact and form complex realities (Stutchbury, 2022).

In embracing relativism, critical realism suggests that perspective is shaped through interactions with others, and that meaning is socially constructed (Proctor, 1998). As individuals engage in these social interactions, there is no singular, universal truth; instead, multiple 'truths' can be identified, each shaped by the social, cultural, and political contexts of a given time and place. Thus, knowledge itself is an 'artifact', a construct that is negotiated and formed within specific contexts (Wigginton & Lafrance, 2019). Yet, in embracing realism, critical realists assert that there are certain structures, procedures, mechanisms, policies, and rules that produce 'things' that are observable (Bhaksar, 1978; Parker, 2002). Aligning with this position, I consider study participants' views as unique to their experiences; yet, capable of conveying tangible meanings that can be shared and interpreted.

Adopting a critical realist position in this research is particularly appropriate as it allows for the integration of historical facts with a deeper understanding of their significance. This position assumes that participants' experiences are shaped by social structures which, in turn, influence their perceptions. By combining social constructionism and critical realism, the research situates participants' experiences within the social context in which they occurred, providing a richer understanding of how these experiences contributed to the broader cultural shift in attitudes towards childbirth.

### 4.3 Epistemology

Epistemology refers to the philosophical position that shapes how researchers approach the production of knowledge. It guides the process of exploring reality (Crotty, 1998), thereby influencing the selection of research methods. In essence, epistemology outlines the way a researcher develops their line of inquiry, grounded in their philosophical stance (Kivunja & Kuyini, 2017). In my research, I adopt an

interpretivist approach, a branch of epistemology that acknowledges the researcher's active involvement in the research process. From this perspective, complete objectivity, as advocated by positivism, is not attainable (Spector-Mersel, 2010). Furthermore, interpretivism emphasises that knowledge is a socially constructed phenomenon, shaped by diverse perspectives and meanings. It recognises that there is no singular, fixed interpretation of reality.

Thus, in exploring the narratives of the individuals who were instrumental in shaping the midwifery profession in New Zealand, I came to the realisation that there is no singular reality. Rather, multiple realities coexist and are collectively (socially) constructed. The epistemologies of social constructionism and critical feminism are now discussed in further detail.

#### 4.3.1 Social Constructionism

Social constructionism asserts that knowledge and meaning are created through societal influences and social conditions. Understanding of the world is shaped by the interactions individuals have with others (Proctor, 1998) and within the relationships they engage in (Gergen, 2011). Perception of behaviour is reinforced by the cultural and social contexts in which individuals live, meaning that there is no singular 'truth' to be discovered (Burr, 2015). An individual's worldview evolves through personal experiences, individual narratives, and the cultural environments they inhabit. Social constructionism challenges assumptions about reality, urging individuals to question both their perceptions and the interpretations they form based on those perceptions (Burr, 2015; Gergen, 2015).

In this research, I focus on participants' subjective narratives of historical events surrounding the childbirth movement in New Zealand. Adopting a social constructionist epistemology allowed me to explore these narratives as each participant's perceived truth, within the social context of New Zealand and the cultural changes over time. Burr (2015) argued that understanding historical and cultural contexts is essential to interpreting social realities. Thus, during the interviews, participants and I reflected on the historical context of their experiences compared with the present day. Integrating cultural context into the analysis added depth to their accounts, moving beyond a mere recounting of events (see also sociality,

temporality, and place, Chapter 5, section 5.7.3). In this way, the research process became a co-construction of meaning, where the participants and I contributed to the retelling of their stories, enabling a richer understanding of their individual and collective experiences.

### 4.3.2 Critical Feminist Theory

This study is fundamentally focused on women, their reproductive and professional lives, and is centred on the female experience. Given this emphasis, the research adopts an overtly gendered orientation, making critical feminist theory an appropriate lens through which to view these participants' experiences.

Critical feminist theory is concerned with the subjugation and subjectivity of women and how this relates to gender discrimination (Weir, 2021). There are existing patriarchal structures evident in the socially constructed medical system (Grant & Osanloo, 2014) compared to traditional midwifery systems.

This theoretical lens allowed me to identify how different power structures operate within a primary health view versus medicalised view of pregnancy, labour, and birth and the context of midwifery. The research participants discussed their intentions to create a maternity system based in a holistic, matriarchal-partnership model which favoured wellness rather than illness. However, over the timeframe this research covers, the socially accepted technological medical model dominated and was perpetuated by practitioner management of childbirth. Critical feminist theory aligns with social constructionism, recognising that power relations and dominant ideologies are socially constructed and reinforced through cultural and institutional practices. It identifies how the maternity system has been shaped, perceived, and managed. Additionally, this lens will be used to identify how power and control mechanisms operate within the current social systems which educate, employ, and govern midwives.

There has been insufficient attention given to the gendered context of childbirth, both for midwives and mothers in the development of the New Zealand midwifery, prior, during, and since the passing of the Act. Much of the existing research has concentrated solely on midwifery education and practice, or obstetric problems, neglecting the factors which have shaped midwifery over time. This gap in research

has led to a poor understanding of the complex relationship between midwifery, women, and the medical model. This research offers a more holistic perspective on the midwifery profession by overtly drawing upon the critical feminist lens when considering the broader context of the New Zealand medical system.

#### 4.4 Narrative Inquiry as Methodology

Narrative inquiry is a qualitative research methodology that centres individuals' stories to gain insights into their experiences. The central premise of narrative inquiry is that by sharing their stories, individuals attribute meaning and order to their life experiences (Josselson, 2013; Kim, 2015). My decision to use narrative inquiry was influenced by my research interest and alignment with the epistemologies of social constructionism and critical feminist theory, as well as the ontology of critical realism. Specifically, I sought to understand, through the experiences of this group of participants, their journey towards achieving midwifery autonomy. By eliciting perspectives from participants who are regarded as experts within this study, I captured a complex and nuanced understanding of their experiences; insights that have not previously been widely circulated.

In planning the research, I anticipated that the storytelling nature of narrative inquiry (Lieblich et al., 1998) would resonate with the participant group and be well suited to capturing their experiences. Many participants were willing to share their stories at length, well beyond the 60-minute time frame initially planned, which further affirmed my expectation. As a former midwife in New Zealand who had two home births, my own professional background inevitably shaped both the way the stories were shared and the analysis of those narratives. Using narrative inquiry, participants were able to share their experiences in their own words; their collective reflections highlighted both the successes and challenges within the New Zealand midwifery profession.

Clandinin and Rosiek (2019) suggested that narrative inquiry seeks, "knowledge of human experience that remains within the stream of human lives" (p. 44). This perspective emphasises that narrative inquiry is not merely about recounting events; rather, it is about embedding the human experience within its broader context, thereby adding layers of meaning to the story. I approached the participants' narratives with this understanding in mind. When asking about their involvement in

the home birth movement or midwifery, I deliberately avoided imposing a rigid set of structured questions. Instead, I opted for open-ended prompts, such as 'What was that like for you?' This approach allowed for a more fluid conversation that prioritised the subjective meaning-making of the participants, aligning with the belief that there is no singular or objective truth (Fraser, 2004; Hollway & Jefferson, 1997). My focus was on how participants constructed meaning within their own narratives, recognising the dynamic interplay of personal experiences, historical context, and social influences.

#### 4.4.1 Narrative Alignment with Social Constructionism

Social constructionism asserts that reality is shaped through social interactions (Nightingale & Cromby, 2002) and that one's worldview is constructed through the narratives they internalise (Clandinin & Rosiek, 2019). Thus, understanding of the world is not an inherent truth but is socially constructed through interactions with others (Proctor, 1998). These interactions, embedded in historical and cultural contexts, influence one's beliefs about what is morally correct, rational, and true (Gergen, 2011). As a result, the narratives individuals hold are seen as personal truths, which they share with others, reinforcing these stories through repetition and solidifying them as reality. However, while individuals often perceive these narratives as 'truths', they are not fixed or universal but are subjective interpretations of reality (Burr, 2015) shaped by individual experience. In line with this view, it has been argued that the most effective way to understand a person's inner world is through the stories they tell (Clandinin & Connelly, 2000; Lieblich et al., 1998). Importantly, since stories are recounted from a point of hindsight, the narrator's perspective is inevitably influenced by time and reflection (Kim, 2015; Spector-Mersel, 2010). By privileging the lived experience of the participant, their personal truth can be validated, though the social context in which their experiences occurred must also be considered (Clandinin & Rosiek, 2019). Lieblich et al. (1998) further highlighted that sharing narrative experiences is central to how societies communicate and make meaning.

Although narrative inquiry places the responsibility on the researcher to retell and interpret participant narratives, the narratives are socially constructed between participants and the researcher within the interview setting (Josselson & Lieblich, 1995; Kim, 2015); thus, this task cannot be accomplished in isolation. The interpretation of these narratives is inherently dependent on context.

In the following chapter, I explore the interplay of temporality, sociality, and place, which are crucial in contextualising the narratives shared by midwives and the consumers (grassroots home birth activists). These elements provide the tools to assist in identifying narrative categories that provide a foundation for the deeper understanding of the participants' experiences. In linking temporality, sociality, and place to social constructionism, temporality highlights how meanings shift over time, sociality underscores the relational nature of knowledge, and place situates experiences within specific cultural and physical environments—all of which shape and influence the construction of reality (Kim, 2015).

#### 4.4.2 Narrative Alignment with Critical Realism

Narrative research and critical realism share a complementary relationship, as both aim to identify deeper layers of reality. Narrative research presents individuals' lived experiences and the meanings they ascribe to events (Clandinin, 2006), providing insight into the subjective and contextual dimensions of human life (Atkinson, 2007). Critical realism offers a philosophical position that recognises the existence of objective structures and mechanisms that influence and shape those experiences (Proctor, 1998). By integrating these approaches, I have explored personal narratives situated within the broader socio-cultural, historical, and institutional contexts of individuals and their collective realities (Crowther, 2019). Individual's perspectives shape their reality, through their experiences. Together, narrative research and critical realism offer a nuanced perspective that balances the subjective interpretation while acknowledging the previously understood historically recorded 'truth' (Spector-Mersel, 2010).

#### 4.4.3 Narrative Alignment with Critical Feminist Theory

Narrative inquiry aligns with critical feminist theory in that the emphasis on language shaping experience (Wigginton & Lafrance, 2019) resonates with narrative inquiry's focus on how stories are told, whose voices are heard, and how those stories are framed (Clandinin, 2006). Critical feminist research is concerned with how the researcher shapes questions, whose voices are prioritised, thus I intentionally used open-ended questions, allowing the participants to control what experiences they would share during the interviews, I only posed one opening question focused on

asking how they came to midwifery or the home birth association. Dominant discourses are often inadequate for expressing women's experiences, as they tend to reflect patriarchal interests (LaFrance & Wigginton, 2019). Narrative inquiry, like critical feminist theory, requires reflexivity in the research process (LaFrance & Wigginton, 2019) and in acknowledging the researcher's influence in shaping both the questions and the meanings derived from participants' narratives. In my desire to co-construct the research with participants, I was deliberate to open interviews with little structure so that the interview would not be dominated by my preconceived ideas. Rather, participants could share their experiences through the telling of their stories.

I felt that this approach was particularly relevant as their accounts reflect how their personal and professional identities have been shaped by dominant discourses within a paternalistic medical model. The use of narrative inquiry, coupled with a critical feminist theory, allowed participants' experiences to be understood not as isolated events, but as contextually and socially constructed responses to systemic othering, gendered power imbalances, and evolving professional pressures.

#### 4.5 Axiology

Axiology refers to the values a researcher brings to the research process (Smith & Thomas, 1998), which play a critical role in ensuring a balanced interpretation of the findings (Kivunja & Kuyini, 2017). Like ontological and epistemological positions, axiology shapes the overall research design and contributes to the theoretical positioning. This study adopts a social constructionist perspective, recognising that 'reality' is co-constructed by both the researcher and the participants. My personal values and biases have influenced various aspects of the research process, including the development of the research questions, selecting the research methods, participant identification, and data analysis. In reflecting on my values, background, and life experiences, I engaged in a process of reflexivity to identify and acknowledge any biases and presuppositions which I brought to this research. I recognise that researchers inevitably shape the research process, and my own positionality is explored in the next section.

## 4.6 Reflexivity

I was drawn to a qualitative narrative inquiry methodology in reading about the co-construction of knowledge with participants. It appealed to me because I came to New Zealand as a home birth midwife, having attended direct-entry midwifery programme. I was a consumer of the maternity system, having two home births. I anticipated that I might share similar beliefs around midwifery and childbirth as the study participants. My personal and professional midwifery experience, along with my previous qualitative research work, gave me the confidence to undertake a research project of this magnitude.

According to Guba and Lincoln (1994), a research paradigm is the set of beliefs a researcher holds based on their worldview or axiology. I gravitated towards using narrative inquiry methods and methodology as it parallels my own beliefs, both in the philosophically and theoretical positioning.

The research participants shifted the maternity system from what was once a heavily medicalised childbirth model mainly within tertiary hospitals towards one that became woman and family centred facilitated by midwives. This qualitative research aimed to collect stories from the midwives and health consumers involved in shaping the midwifery profession between the 1970s to 2023, when they were interviewed. In the narrative approach, it was important for the participants to feel comfortable and a sense of equality with the researcher (Moen, 2006). Therefore, I felt it was important that participants knew I came from a direct-entry midwifery programme with a strong primary and home birth background; thereby establishing a connection and professional and collegial rapport.

## 4.7 Theoretical Positioning of the Researcher

My assumptions and theoretical positioning were discussed with my supervisors during a 'pre-understandings interview' before the commencement of the research. This process facilitated self-reflection, heightened awareness, and reflexivity, which I continuously referred to throughout the research process.

In terms of my professional midwifery journey, I trained as a direct-entry midwife at Miami-Dade College and practiced as a home birth midwife in South Florida, US. Like

the five consumer participants in this study, my two children were born at home, as planned, in New Zealand. They were born after 1990 under the midwifery model initiated by the Act of 1990, which was developed by the study participants.

I was the first midwife from Miami-Dade to become registered in New Zealand in 2004. The only requirements set on my practicing certificate by the Midwifery Council were to complete a cultural Treaty of Waitangi paper and one focused on prescribing for midwives, a distance paper through Otago University.

I had anticipated that working within a maternity system set up by midwives would have a strong focus on primary birth and the physiological mechanisms of labour and birth, through to the postnatal period. However, when I became employed as a core hospital midwife, I found that my colleagues had a very medicalised approach in their management of all patients presenting in labour and immediate postnatal care. This surprised me because New Zealand is a socialised health system; although the majority of primary health maternity services are delivered mainly in tertiary hospitals (MoH, 2022).

As with many New Zealand midwives, I had the opportunity to work in a variety of environments; as an independent midwife I attended births at home, in primary units, and in several hospitals around Auckland region. I was a core hospital midwife and later I facilitated childbirth education classes in a primary maternity unit while I completed my master's in public health.

My curiosity of the Nurses Amendment Act ignited from my work within both the hospital system and the community, as I could not understand the incongruencies between the midwifery model, partnership, and the ever-increasing interventions at the hands of midwives. Although my daughters were born in different cities, and with 12-years between their births, I became aware of the increased reliance on technology, rather than traditional midwifery skill. For example, at an antenatal visit, the senior student popped the doppler on my belly without first palpating and looked at the doppler reading while I looked at my watch to calculate the foetal heart rate. The doppler provides an averaging of the heartbeats and is not an accurate reading from a traditional skill standpoint. I do not believe she knew the difference.

Having worked on the New Zealand midwifery sustainability research through AUT as a research officer (McAra-Couper et al., 2014; Gilkison et al., 2015; Hunter et al., 2016), and having considered what sustained midwives in their independent practice, led to a curiosity of historical events which landed me to consider the midwifery profession becoming independent from medicine in 1990.

#### 4.8 Overview of the Theoretical Positioning

The following outlines the theoretical positioning of the thesis including the methodology and methods used.

##### **Thesis title**

New Zealand Midwifery's Journey Towards Autonomy: A Narrative Inquiry

##### **Research objective**

To collect narratives from participants who contributed to developing the midwifery model defined by The Nurses Amendment Act, 1990.

##### **Research paradigm**

Qualitative

##### **Ontology** (Nature and form of being)

Critical realism

"Referentiality and objectivity are possible, though always partial, limited and necessarily dependent upon further empirical and discursive revision.

The evaluation as to the accuracy of our accounts becomes possible"

(Nightingale & Cromby, 2002 p. 710).

##### **Epistemologies** (Nature of knowledge)

Social constructionism

Reality is socially constructed.

Individuals create multiple realities even within the same context

(Burr, 2015).

##### Critical Feminist Theory

Explores aspects of power and control through the researcher's questioning of the socially constructed reality (Wigginton & LaFrance, 2019).

### **Axiology**

Researcher's values in relation to the research process  
(Smith & Thomas, 1998).

### **Methods** (next chapter)

Narrative interviews

Semi-structured interviews guided by open-ended questions

### **Narrative analysis**

Categorical-content narrative analysis (Lieblich et al., 1998)

Data interpretation and analysis are the processes of transforming narratives to gather information, make new meanings and provide conclusions  
(Lieblich et al., 1998; Zilber et al., 2008).

### **Narrative tools/ narrative thread**

Temporality, sociality, place

### **Research questions** (as presented in 1.2.2)

- What aspirations did participants have for maternity care, and how did they envision their role in shaping its transformation?
- How did participants experience the maternity system prior to the enactment of The Nurses Amendment Act 1990, what challenges did they encounter?
- How did participants navigate their professional relationships with other maternity care providers, and what influenced these interactions?
- How did the formal professionalisation of midwifery impact the financial sustainability and autonomy of independent midwives following the passing of the Act?
- What challenges did midwives face in securing recognition and legitimacy as primary maternity care providers within the healthcare system?
- How have participants sustained their commitment to physiological birth and midwifery autonomy over time, despite systemic constraints and professional marginalisation?

## 4.9 Conclusion

This chapter has provided a detailed outline of the theoretical positioning of the thesis, including the ontological and epistemological positions that guide the research. It also highlighted the methodological approaches employed throughout the study. The chapter concluded by exploring the relationship between social constructionism and narrative methodology, culminating in an overview that visually represents the theoretical nature of the research. The following chapter presents the research methods used to gather and analyse data for the study.

## Chapter 5 Methods

The previous chapter outlined the philosophical stance of the research. In this chapter I present the methods. Section 5.2 provides a theoretical description of narrative research method theory and defines metanarrative. Sections 5.3 onward, describe the practical steps of the methods which include participant description and recruitment methods. The use of narrative interviews, transcription, and analysis steps are outlined. The chapter concludes by discussing limitations, rigour, and ethical considerations for the study.

### 5.1 Narrative Research Method

Narrative inquiry is both a methodology and a set of methods within qualitative research. The method enables participant experiences to be presented within the cultural context and, because the story is told in the participant's own words, it allows the story to retain personal elements, its essence, and richness. By examining a participant's story, narrative inquiry gains insight into a phenomenon, rather than simply gathering a series of facts. The principal notion of a narrative inquiry is that an individual, in sharing their story, gives meaning and order to their own life experiences (Josselson, 2013; Kim, 2015). As well as rendering meaning, storytelling has been described as a primary strategy for humans to make sense of their existence within the social world (Bruner, 1990). Connelly and Clandinin (1990) denoted narrative inquiry as one of the best ways to study the human experience. However, the research process is more than a retelling of a story, as methods include interpretation, analysis, and a series of reconstructions of the story (Polkinghorne, 1995; Riessman, 1993). Clandinin (2022) indicated that researchers situate themselves in a relational way with participants, while Riessman (1993) added that relational positioning allows the researcher to reconstruct the story more easily through the processes of transcription, analysis, and interpretation.

In addition to reconstructing the narrative, the researcher's decision making sets the context for the story (McCormack, 2000). I determined the research questions, which shaped the focus under investigation, while simultaneously identifying the inclusion and exclusion criteria for participant selection. Additionally, in developing interview

questions I considered what topics participants could speak to. In this way I was responsible for directing the study path and establishing whose narratives would and would not be obtained (Murray, 2009). These decisions dictated the collection of the raw data which then became used for analysis and the findings presented in this thesis. I was mindful to consider the delicate balance of which aspects participants felt their story should convey versus what was central to the line of inquiry (Creswell, 2007; Kim 2015).

As narrative inquiry positions itself on the supposition that there is more than one understanding and interpretation of a story, when narratives are told and re-told over time they shift along the social and cultural narrative (Clandinin, 2022). The narrative approach uses storytelling to identify nuances within an individual's life (Sharp et al., 2019). I used an inductive approach rather than presenting with a hypothesis when collecting the narratives and developed presuppositions after familiarising myself with meanings assembled from fieldnotes and transcripts.

McQuillan (2000) highlighted narrative inquiry as having the capacity of a two-fold impact for the participant and the researcher, in the telling and within the knowing. Atkinson (2007) extended the idea of narrative impact by suggesting that the researcher is initially assisting the participant in telling their story with reflective open-ended questions to bring out a subjective meaning. The researcher identifies narrative categories across the stories which become evident within the study (Bright & Du Preez, 2023).

The onus sat with me, the researcher, to convey meaning while interpreting a participant's story (Josselson & Lieblich, 1995; Kim, 2015). Yet, how does one prepare for the responsibility? I used the participants' edited transcripts, along with my field notes, to guide my interpretations (Sandelowski, 1994). I spent time reviewing my field notes and re-listening to audio interviews which provided me a level of comprehension that I would not have accessed by simply reading the transcripts. Utterances, such as laughing, crying, sighing, assisted in creating a broader meaning of the story being shared (Sandelowski, 1994).

Along with listening to the interviews numerous times (Clandinin & Connelly, 2000), I read, reviewed, and re-read transcripts in early stages of the data collection to

recognise broad categories across the collection (Lieblich et al., 1998; Riessman, 1993). In line with Josselson and Hammack (2021), my intention was not to collect a uniform data set, rather to identify similarity and variability across stories while maintaining focus on the narrative threads which answered the research questions.

I read newsletters and published works of participants to further interlink the participant within their context (Moen, 2006) and around the phenomenon. One participant suggested I contact a midwifery school to access their archive, which was 12 storage filing boxes containing embargoed, confidential, and unpublished material dating back to 1987. The contents included hospital board meeting minutes, embargoed speeches from the Minister of Health, confidential responses drafted by lawyers to individuals and midwife organisations, newspaper clippings, and unpublished grey literature. The embargoed and confidential material were no longer considered sensitive or legally significant in 2023. Upon its collection, the material, was referred to me as that, 'old stuff,' in the back of a cupboard and since accessing them, I have taken steps to ensure their preservation and appropriate stewardship by placing them into a proper archive. In some cases, I liaised with the subject-specialist librarian at AUT to ensure the artifacts were donated to the school library. The research ethics committee's primary concern is with studies involving human participants and as such, it falls outside their purview.

I read Home Birth Association meeting minutes, Save the Midwife newsletters, and *Broadsheet* magazines where there was alignment to the research questions. Doing so was crucial in gaining insight into some of the participants. I read the masters dissertations and PhD thesis of the participants which focused on midwifery practice (Griffiths, 2019; Gunn, 2001; Hendry, 2003; Miller, 2008; Young, 2011), the development of the midwifery system (Pairman, 2005; Guilliland & Pairman, 2010; Grigg & Tracy, 2013), and midwifery education (Gilkison et al., 2013); while some focused on consumer influences and social movements within health (Christison, 2001; Daellenbach, 1999; Daellenbach & Thorpe, 2007; Donley, 1992a), and, another source, a personal account of career highlights (Skinner, 2023).

The above preparatory reading allowed me to identify a gap in the subject knowledge, and the personal voice narratives of these individuals (Clandinin & Connelly, 2000).

Although I was using an inductive approach to the interviews, reading participants' publications gave me a sense of their personal and professional research interests and background knowledge about them as individuals. This was extremely beneficial when meeting with participants whom I had not known professionally before the interview. When appropriate, I informed participants of this prereading at the onset of each interview.

I had prepared an open-ended interview schedule; however, I wanted the participants to guide the interviews. Hence, I posed follow up queries for clarification when a participant alluded to an event or situation and had not fully elaborated. One prompt was, 'what do you mean by that?' Thus, it was the participants who actively guided the interview and the social interaction between us (or the group) aligning with social construction epistemology (Earthy & Cronin, 2008).

Within social constructionist and critical feminist theories, the narratives shared during interviews are intersubjectively co-constructed by both the interviewer and interviewee (Gergen & Gergen, 1988; Lafrance & Wigginton, 2019), meaning the resulting story emerges through the interaction of two conscious minds. During the research process I was conscious of my involvement in co-creating a research experience with participants during the interview. When participants shared with me their original experience, that event, an intangible experience, became something more concrete. The new experience within the interview differed from the original event which became their story (Lieblich et al., 1998). Polkinghorne (1988) suggested the raw material is what happened to the participant, and Moen (2006) indicated that the participant's experience becomes the collaborative experience when converted into text after the interview. Building on these ideas, a critical feminist lens shaped the direction of the narrative, recognising how power, gender, and social structures influenced both the participant's lived experience and the process of co-constructing their story.

Narratives are dynamic in that every telling of a story is slightly different (Nightingale & Cromby, 2002; Proctor, 1998) and, depending on the research focus, the transcript data could potentially be used to answer several different research interests (Burr, 2015; Gergen, 2011) and tailored for different audiences. Having the advantage of my

extensive pre-reading, I noticed slight variations within participants' stories when I had been aware of an excerpt of story before an interview.

Although co-created and shared, Crotty (1998) indicated that the interpretation sits with the researcher. The findings are presented in Chapters 6, 7, 8, 9, and 10. The interpretation of the findings are elaborated in the metanarratives in the conclusion and discussion-Chapter 11.

Understanding a narrative can only be attained after the context has been presented (Riessman, 2008). Zilber et al. (2008) further indicated that together the text and context create a whole. Connelly and Clandinin's (2006) elements of temporality, sociality, and place were used as tools to assist in organising participants' transcripts and to provide a contextual foundation for narratives; thereby forming the narrative threads of the findings, Chapters 6-10. In addition, these three elements assisted with narrative analysis and in identifying narrative categories within transcripts (see sections 5.6 and 5.7.3).

As metanarratives are defined in various ways throughout the literature, I will elaborate and explore the context which has been used to interpret and analyse the interview transcripts within this thesis.

## 5.2 Metanarratives and the Narrative Context

The prefix 'meta', borrowed from the Greek, indicates 'after' or 'along with', 'beyond', 'among'. Coupled with the word narrative, meaning 'story', a metanarrative comprises a 'story' 'beyond' or 'along with'; 'story' effectually meaning in 'addition to' or pronouncing the interpretation of the story. In this thesis I use the definition of metanarrative as the research story brought together by all the component parts (Bold, 2012). By this I mean that the metanarrative is considered beyond simply the words which are spoken. The entirety of the story is considered together so that meaning can be derived beyond a first assumption of understanding (Bright & DuPreez, 2023).

Within narrative inquiry, the focus on the participant's experience informs the inquiry, and explores the social, cultural, familial, and linguistic narratives within the story (Clandinin, 2022). Elements of temporality, sociality, and place (section 5.6.3) are

evident within the publications and the historic writings of the time focused on in this thesis. Chapters 2 and 6 provide the contextual background to the inquiry, highlighting the temporal and socio-geopolitically constructed realities within which the narratives presented in this thesis are told and re-told. The stories individuals tell are socially constructed, developed over many retellings, and take shape depending on the audience. In this way, narratives develop and can become redeveloped within the context of time, space, and place. Authenticity, in this context, lies not in determining which version of the past is true, but in understanding how each narrative reflects the participant's evolving interpretation of their experiences within moments of time, space, and culture. These stories, reshaped through memory and retelling, offer insight into how meaning is constructed and reconstructed, allowing us to learn from the past as it is lived and remembered, rather than as a fixed historical fact.

The collective narrative is used in understanding a metanarrative as it represents the wider story (Bold, 2012). Collective narratives, as a whole, emphasise the relative story acting within multiple truths (Josselson & Hammack, 2021). As the researcher holding the entire shared story, I was interpreting aspects of participants' perspectives as it related to the whole of the story, while listening to their account of the story. In having multiple shared stories, I was able to capture, in my mind, aspects of the stories which had not been discussed by participants (Bright & Du Preez, 2023).

Josselson (2013) indicated the interview is limited to what has been disclosed and this often is dependent on the relationship between interviewer and interviewee. Although the raw data which results from the interview and transcript review is co-constructed, the interview content has set parameters. Additionally, participants did have an opportunity to attend an online cost-neutral presentation I gave on International Midwives Day; 5th May 2024. I explained in that online presentation that my analysis was not yet finalised. Those who attended the online presentation did offer points that they felt needed to be included in the study. Their feedback broadened my scope of Chapter 8, titled, *Othering*, by specific inclusion of additional quotes from their interviews.

Therefore, the final interpretation is, ultimately, left to the researcher to garner and create meaning. The co-constructed data used during the analysis is socially

constructed through the context of narrative elements-temporality, sociality, and place. The wider metanarrative aligns well with the social constructionist epistemology (Nightingale & Cromby, 2002) because in constructing the narrative within the context, the stories take on cultural, temporal, and social meanings (Connelly & Clandinin, 2006; Lieblich et al., 1998). Taking an example from this research, midwifery education may have remained within the Nursing Council; yet, New Zealand has 30-years of midwifery education which has been modified over time. These changes in midwifery education are reflected in universities' pedagogical content, focus of research content, and within midwifery practice. In the next sections the research methods and the participants of the inquiry are presented.

### 5.3 Ethical Considerations

Ethical approval was granted by AUTEK on 15 December 2022, number 22/360 (Appendix A). The ethical considerations within this thesis include the plan for direct recruitment and naming of participants. While ethics committees generally prefer individuals to be contacted through indirect techniques (Braun & Clarke, 2013), I sought to engage a specific group of experts to answer the line of inquiry. The focus of the research was regarding their professional work, although in some cases this crossed over into their personal lives. As previously discussed, these midwives, as the main group of participants, publicly advertised their contact information for case-loading. At that time, there was no delineation between their personal and professional telephone number and then, much later, their email address. The consumers, selected from the Save The Midwives newsletters, also included their telephone numbers and home addresses, inviting the public to contact them for contribution to the newsletters or memberships. AUTEK did request I contact potential participants on their work emails, in the first instance when available, and this advice was followed.

In all the documentation, I was explicit in my decision that by participating in the research, participants were consenting to include their real names. I was not (initially) intending to provide pseudonyms. I wanted to include their names because the names of these women are not overtly stated within historic texts. Every midwife that became an independent practitioner after 1990, every student that graduated from a

direct-entry programme since 1993, every international midwife that has immigrated to New Zealand to practise, such as myself, was able to do so because of this courageous group of women. Internationally, midwifery in New Zealand is held in the highest regard because of the work of these participants. However, many people are not aware of their plight or the struggle to gain professional independence. Today their efforts are taken for granted. Thus, because these women had already advertised their own names, I took their lead and requested their permission to name them in the research, during the consenting processes.

In two instances, after transcribing interviews, I did decide to use pseudonyms. One participant I felt could potentially be identified and because she was still working at the time of the interview, during my write up phase I contacted her with the section I wished to use and requested she choose a pseudonym. I did not want her to be vulnerable to any retaliation, and she selected a pseudonym for her quote. The other participant (section 8.3.1) worked in central government, and I did not want them to be identified because of their testimony. While my inclusion criteria evolved, as often happens within narrative inquiry methodology, I was diligent in maintaining strict adherence to all ethical guidelines and approvals.

### 5.3.1 Data Protection

Digital audio recordings and transcribed interviews are stored on a password protected computer in a locked office. Paper copies, such as the printed and handwritten-on transcripts, were scanned and saved on a password protected computer. All study materials are kept in a password protected computer in a locked office at AUT and will be destroyed in 6-years following completion of the study as per local ethical procedures.

### 5.3.2 Recruitment Procedure

Purposeful sampling and direct email recruitment were utilised. My justification for direct email was that the self-employed independent midwives in New Zealand, in a general sense, do not have a buffer between them and the public seeking midwifery services. The participant group had professionally relied on fielding cold calls over the phone from people who were looking to engage a midwife. The midwife participants did not have secretaries or medical receptionists employed in a type of medical centre

such as GP or obstetrician's office. Midwives advertised in the public domain and their personal phone numbers, and at times their home addresses, were publicly available. The consumer participants' names were taken from newsletters found online. Their phone numbers and addresses were also publicly advertised, mainly because at the time that was the only way to contact people. To increase their membership, they needed to advertise. Two of the participants were contacted via Facebook messenger; and as we shared several mutual 'friends', I sent a direct message requesting their email address. Once I obtained the email address, the same recruitment process was followed. My Plunket nurse (well child nurse), who is also a midwife, offered me her sister-in-law's (Karen Guilliland) email address when I explained to her what my research was about.

The purposeful sampling technique and direct recruitment were employed to ensure that inclusion criteria were met (Crotty, 1998). Forty individuals were identified as potential participants, and 26 individuals were recruited and self-selected to be interviewed. The introductory email outlined the research purpose including a justification for contacting them. A summary of expectations was also provided. The participant information sheet stated that the research was to explore the experiences of the individuals across Aotearoa New Zealand who were involved in the home birth movement in the late 1980s prior to the 1990 Nurses Amendment Act (Appendix B).

Throughout the data collection process, I sensed that the inclusion criteria needed to evolve to allow for a counternarrative from the Ministry's perspective. Using the previously identified snowballing method, participants provided me with the names of individuals they had worked with over the years, and I directly contacted them via their work email address.

Attached within the recruitment email were the participant information sheet (Appendix B) and consent form (Appendix C), to ensure individuals were given a detailed account of the research focus and why they were being contacted. The information sheet and consent form outlined what participation would entail, including digital recording of interview, anticipated length of interview and transcript review, and koha (gift donation for their time). Also indicated were parameters around how many participants were anticipated for interviews (12-20). Both the participant

information sheet and consent form were explicit in advising that participants would not be anonymous and that their names would be used in the PhD thesis as well as publications.

As stated in documentation approved by ethics, the recruitment email included my email and phone number, and individuals were asked to respond within a 2-week period. They were advised that if I had not received a response after a fortnight, they would be sent a single, final email. In the instance where no response was received in 4-weeks from the second email, they were not contacted further. A lack of response would have been considered a lack of interest, and I did not want individuals to feel coerced. However, all the participants were prompt in their responses; I had received response emails in less than one week.

Interviews took place between March and July 2023. When individuals responded, we negotiated dates and times for interviews. Where participants were residing local to me, Northland to Waikato, I organised a private location for interviews. In areas outside Auckland, participants were asked to identify a private and suitable location for the interview. Seven of the midwife participants were interviewed in their home, consumers were interviewed in an office space at my workplace, one at her own workplace, and one interviewed over Zoom. When participants opted to be interviewed in their private residence, my supervisors were advised of the date, time, and location of the planned interview. However, as most participants were members of the same professional organisation as myself, the New Zealand College of Midwives, risk to the researcher was considered very low.

After I conducted three interviews, I noticed that I had worn the same outfit in all interviews. Although initially unintentional, I decided to continue wearing the same ensemble which became my interviewer 'uniform' for all interviews. Besides being practical, the uniform allowed me to focus on my 'researcher' role, which for me delineated the other aspects of my life such as my family and employed work from my 'self' as researcher.

## 5.4 Participants

The participant population invited to this research are experts who were involved in childbirth activism and New Zealand midwifery from the mid-1970s. Inclusion criteria for participation was identified as; an individual who was involved in the grassroots childbirth movement (i.e. Home Birth Association members and domiciliary midwives). Key experts involved in preparing The Act in government (such as Helen Clark). Therefore, the exclusion criteria were any person who does not meet the inclusion criteria. A purposeful sampling technique and direct recruitment were employed to ensure that inclusion criteria were met (Crotty, 1998). The midwife participants developed the midwifery profession after getting the Act passed and went on in their career trajectory to hold the highest professional positions within clinical practice, midwifery education as academics or researchers, within the Ministry of Health, and within positions of governance, the College of Midwives and Midwifery Council. Four of the five consumer participants also continued their work in health and educating midwives. Some of the individuals at the time of the interview were enjoying retirement. Others were still employed, although apart from one, all others were not actively attending births in midwifery practice. **Table 1** overviews the participants including their career history. As the research inquiry is specifically focused on collecting narratives from these individuals, expert informants were selected through contacts within the midwifery community.

To gather a varied cross section of experience, I purposefully selected participants across New Zealand. Although there is one national maternity system, there is a broad range within independent practice which seems to be historically based rather than evidenced based. For example, most of the hospitals in Auckland are more medically focused whereas rural hospitals offer services reflecting primary health. This means that even primary births in Auckland tend to follow a more medical path. All participants who were contacted were either known to be practising domiciliary midwives, involved in the home birth movement in the mid-1970s, or involved in maternity services. It was believed that as experts involved with the reformation, their experiences could shed light on the early development of the midwife-led system and evolution towards the maternity system in 2023. These individuals had contributed to the development of the primary health midwifery model as defined by the Nurses

Amendment Act, 1990. To offer a temporal perspective, some participants interviewed were able to share insights into maternity in 2023, comparing modern day attitudes to historic attitudes.

I was familiar with many of the individuals who met the inclusion criteria; however, I had not personally met every individual prior to contacting them for an interview. Selected participants had been childbirth 'consumers' (these individuals self-identified as 'home birth advocates') or domiciliary midwives that became independent midwives after the Act passed. The decision to include both consumers and midwives was intentional, as the health consumers were the prominent stakeholder voice as a service user and valued asset towards midwives gaining autonomy. The Act would not have become a movement without the consumers, and the midwives and the collective group were stronger together than either of them would have been as separate entities (Guilliland & Pairman, 2010). Additionally, the New Zealand maternity service was developed 'in partnership' with women, which was later recognised as international best practice (Fullerton, Thompson, Pairman, & Moyo, 2011). Aspects of the research focus was to better understand the phenomena of the legislation change, from the consumer perspective. The justification to include home birth midwives was to understand their experience around how the midwifery profession and culture has changed between the 1970s, the shift towards the Act, and throughout the course of their career.

Midway through the interviews, one participant asked me who I was planning on interviewing. The question appeared to stem from curiosity, perhaps to assess whether I had selected an appropriate group of individuals. The query caught me off guard, and I rattled off the names of those most recently interviewed. I was surprised at her response when she retorted, "oh, don't interview her", upon hearing one of the names. It was much later that I considered, perhaps it was not whether I had selected the appropriate group (particularly as participants had self-selected by accepting the invitation), rather that a hierarchy may have existed amongst this group, distinguishing those deemed trustworthy to share the 'appropriate' experiences.

Participants, upon learning the focus of the research, conveyed a clear sense of inevitability about their involvement. Their willingness to participate stemmed from

their prior engagement in research, proximity to midwifery scholarship, or recognition of themselves as natural contributors to this specific topic.

**Table 1** *Participants*

Name & citation used in thesis	DM	HBA	COM	LMC	MOH	Uni	PhD
<b>Midwives</b>							
Carolyn Young (Young, 2011)	■			■			■
Andrea Gilkison (Gilkison, Giddings, & Smythe, 2013)	■			■		■	■
Sian Burgess	■		■	■	■		
Jackie Gunn (Gunn, 2001)	■	■				■	
Bronwen Pelvin (Pelvin, 1988)	■		■		■		
Suzanne Miller (Miller, 2008)			■	■		■	■
Christine Griffiths (Griffiths, 2019)			■	■		■	■
Susan Lennox (Lennox, 2002)	■		■	■		■	■
Joan Skinner (Skinner, 2005)	■		■	■		■	■
Karen Guilliland (Guilliland, 2001)	■		■	■			
Norma Campbell	■		■	■			
Violet Clapham			■	■			
Alison Eddy	■		■	■			
<b>Consumers</b>							
	STM	HBA	COM	Uni	PhD	other	
Rea Daellenbach (Daellenbach, 1999)	■	■	■	■	■		
Brenda Hinton (Hinton & Pot, 1984)		■				■	
Glenys Parton		■					
Joy Christison (Christison, 2001)		■	■		■	■	
Marjet Pot (Hinton & Pot, 1984)	■	■	■			■	
<b>Ministry of Health</b>							
Teenha Handiside	(Helen Clark's aide)						
Anonymised employee							
<b>Key topic experts</b>							
Dee Pignéguy	Joan Donley's daughter						
Tamarin Pignéguy-Davies	Joan Donley's granddaughter						

## 5.5 Data Collection

Narrative Interviews were conducted between March and July 2023. They were one-on-one, apart from the two group interviews of three midwife participants. The five consumers were also individual interviews. The group interviews were conducted outside of Auckland. These participants arranged themselves into groups. After an initial email to one participant, the reply asked for the names of the other individuals in the area that had been included. I sent the names as requested and she responded to advise me that she had set up a group interview with the others. The email included the date, time, and address of the participant's home. The second unfolded when I arrived to interview the participant, who then advised there were others that were going to attend. I had printed additional participant information sheets and consent forms, which I explained and asked them to sign. Although I did not initially contact them, their contributions were invaluable.

One participant chauffeured me to and from the airport, and for one rural interview I spent the night in the participant's home, located a few hours from the closest airport, although no research material was discussed outside designated 'interview time'. Coincidentally, all interviews that took place at the interviewees' residences were with home birth midwife participants; a historical extension of Māori culture adapted by this group as an extension of community orientation.

As the primary researcher, I chose to utilise semi-structured interviews with open ended questions because I felt this would best capture participants' stories (Lieblich et al., 1998). I had read about events that occurred, but I was unable to discover the personal feeling behind this history. My preference was to engage with participants face to face as I was experienced as a clinician and a qualitative researcher with taking personal histories (see reflexivity Chapter 4, section 6). I felt that in-person interviews allowed me to quickly connect with people and establish a positive rapport, when compared to video technology. I prefer the three-dimensional interviewing. It is consistent with narrative methodology, combats technology fatigue, and allowed me to pick up on nuanced whole-body language that I was unable to detect when only seeing a person's face through a digital screen. Connelly and Clandinin (2006) indicated that the physical dynamic between the interviewer and the interviewee in the same

space allows for more conducive open, in-depth discussions which assist in creating rapport. While most of the interviews were held in-person, three interviews took place using Zoom video-conferencing technology due to access logistics and road blockages. At the time of the interviews there were areas of New Zealand which were inaccessible due to flooding and road closures.

The three digital interviews were audio recorded using the same recording techniques as the in-person interviews. All audio recordings were transcribed in the same way. I did not record the digital interviews with a camera. Although I had expected the in-person interviews to have a more nuanced interview result, when I listened to audio during the transcription procedure, had I not known which interviews were held face to face or via digital technology, I would not have been able to differentiate between the two methods. I understand that in semi-structured interviews the researcher prepares a list of general or indicative questions to ask the interviewee (Kim, 2015), and although I did prepare a series of indicative questions, their use was to guide me through considering what questions participants may be asked to inform the ethics committee.

The schedule of open-ended questions (Appendix D) was prepared to accompany the ethics application and identify for AUTECH members what types of questions I may focus on during the interviews. There was a significant gap (3-months) between obtaining ethics approval and approval from the school faculty due to the Christmas holiday. During that time, I continued my reading on the topic and participants' published work, so when it came time for the interviews, I was more confident with the topic overall and the participant's written repertoire.

At the onset of every interview, I facilitated an informal conversation about time frames including food and/or toilet breaks. I followed the participant's lead using their manner as a guide. The interviews varied in length between a prompt 60 minutes and a generous 4-hours. I had anticipated long interviews, as the line of inquiry was set over the 40-year (in some cases 50-year) period of their careers and lives. In line with Riessman (1993), I wanted to provide participants with space to organise their own responses. At times, this meant that their stories were lengthy. For example, before a participant told me why they left work at the hospital to practise as a domiciliary

midwife, they began by telling me what it was like to work in the hospital during the 1960s, sterilising glass syringes and using glass IV bottles.

I was interested in creating a relational atmosphere (Clandinin, 2022), so I opened the interviews with a brief introduction about myself, my background, and described the research intentions. As this formality is a cultural expectation, stemming from Māori influence on protocol and ways of being with each other in New Zealand (Hudson, Milne, Reynolds, Russell & Smith, 2010), the participants would have anticipated this as a standard opening.

Every interview was unique in that I did not begin with a uniform script. As a narrative researcher, I was not seeking a uniformed set of responses, rather to identify similarities across narrative threads against the research questions (Josselson & Hammack, 2021). This was because in some instances I already had a developed rapport with the participant. As such, I opened with a broad question so that participants could control the tone, agenda (Dwyer & emerald, 2017), and cadence of the interview. Most participants were amiable to share their experience, and some began talking before I started recording. Other participants wanted a direct question. Hence, I started the interview with the open question, 'Tell me how you became involved in midwifery?'; or for the consumers, 'How did you become involved in the home birth movement?'

After the first interview, as recommended by Kim (2015), I made detailed field notes and used these as a reflection on the encounter to improve subsequent interviews. I transcribed interviews as soon as possible and one note from the first post-interview transcription was, 'Erin, stop talking!! This is an interview, not a conversation!' This note proved effective as in the later interviews I only spoke when requesting clarification or elaboration. By reminding myself of the intention of the interview I corrected my interview style and observed within the transcripts and recordings that the interviews flowed more smoothly. I found this process to be invaluable and so I continued this reflective practice and note taking throughout the data collection process to refine my interviewing technique.

The open-ended structure allowed me to interject during a pause for clarification. I found that I could return to a word or phrase a participant mentioned and was able to

draw out their line of thought with the open questions. For example, during an interview pause I interjected the question, “and when you were saying ‘really active’ in politics, that ‘consumers now are not necessarily as involved because politics is so different’, what do you mean by that? I’m asking so I don’t make assumptions”.

I found that there was enough flexibility with the semi-structured interviews to allow participants to respond openly. Further, my preliminary reading allowed me to be familiar enough with the participant’s background that I could focus questions on their career. For example, although one participant had been a clinician for many years, she was also involved in the development of midwifery education. Therefore, to capture the whole of her career, I improvised questions to extend on a fleeting comment made (see the example below). Although the example may read as though I was making a judgemental comparison, my statement is synopsised from her previous comments, for her to expand on what she was meaning. Her earlier statement had focused on the difference in learning outcomes and education between midwives versus nurses.

*Erin: The midwifery degree is pretty hard; when you compare it to nursing...*

*Jackie: It is, and that’s because what you’re getting at the end is someone who can go down the road and engage a client. They’re not supervised all the way through the pregnancy, the labour and birth’ and to 6-weeks postpartum. Nobody else sees that client, the client is reliant on all her decisions and that is why it’s longer and why it’s harder.*

As discussed, on two separate occasions, group interviews commenced. During the group interviews there were moments where I felt like a fly-on-the-wall, it seemed that participants were reminiscing with each other rather than being interviewed for research. Participants were relaxed and seemed to be catching up with each other, even finishing one another’s sentences. They talked about historic meetings, conferences, and birth stories, and how much has changed.

- SL: It's extraordinary, the idea that you would leave people when they're*
- CG: It's terrible, it's really hard.*
- JS: And for those of our generation it's just a total tragedy when that happened, a total tragedy because we fought so hard to be able to stay with the woman.*
- CG: We seriously worked thousands of hours for free.*
- SL: And we've all been there, but we weren't paid for that and it's true we should have been paid. I understand that but I still wouldn't walk out on a woman now.*
- CG: And the woman who really need continuity are the ones who just don't get it because midwives leave them once anything abnormal happens*
- JS: That's another issue, yeah.*

Group participants prompted each other during the interview to learn about each other's experiences. For example, one participant asked the others, "where were you when you heard [that the Amendment Act was passed in Parliament?]" and they all shared their story. This had not been a question that I initially had an explicit interest in but, because the response sparked such an emotive response in participants, I brought this question to future interviews. In addition to the collaborative co-construction of the shared narrative, as the interviewer, I at times took a more passive role. I sat and listened as participants prompted each other in discussion. In those moments, I continued my note taking in case something was mentioned that I wanted to revisit when the conversation fell towards a lull. It became evident to me that they were controlling the interview discussion, and it was clear that they felt comfortable to manage their dialogue. That these group interviews took place in a space that someone in the group had selected, may have also provided a protective factor. Being interviewed on their own 'turf', allowing them to be more open and candid. Both group interviews were with participants I had not previously met.

Compared with the groups, and depending on the participant, the individual interviews seemed more formal. (Although most audio recordings depict a great deal of laughter even when I had not been familiar with the individual beforehand). My sense about the formality is that all participants were very passionate about the subject matter, their career, advocacy for women's health, the midwifery partnership model of care,

and their personal and shared history. The longer individual interviews were held in the participant's home and the brief interviews, although longer than planned 60 minutes, were held at the participant's workplace.

Questions were flexible enough to expand the scope of the interview, allowing for story elements to naturally develop based on interviewees' responses. In the interviews I was mentally multitasking, retaining one thought in my head while the participant's story drifted towards another topic. I did not want to interrupt, so I waited for a natural pause and half-listened to what was being said, holding on to the topic that I wanted to return to in my head. In the early interviews, when I reviewed the transcripts along with listening to the recording, I realised I had not always been able to completely concentrate on what was being said and so was like hearing the participant's account for what seemed the first time while reviewing the recording. It was then that I was able to listen with more concentrated focus on what the participant had shared. I took this learning into the next interviews and modified my action by writing down a word or phrase on my notepad to help me recall their comment, phrase, or story line that I wanted to return to.

When it was apparent that interviews were coming to a natural conclusion, due to either a timeframe (set by some of the employed participants) or participants schedules, I asked them if there was anything they would have liked to cover that we had not touched on or was there anything they wanted to add. This tactic extended most of the interviews and several times I had already stopped the recording only to begin a second recording. In three instances a third, brief, recording was made. In the next section, I outline the methods taken to transcribe the interviews.

### 5.5.1 Transcription

My initial plan for transcribing interviews, as indicated in my ethics application, was to email the audio recordings from the interviews to an electronic transcription service. However, after my first interview, I wanted to ensure I had a backup recording on an additional device in the event of a technology failure. Setting this up, I realised the 'voice typing' command in Google 'docs' could be used to transcribe the interviews. I opened Google docs, named the document using the participant's name and the date of interview and saved the file. I started to play the audio recording, and with the

'voice typing' command, the written dictated text transcription appeared on the page. After the recording finished and the transcription ended, I read through the transcript while listening to the recording, I paused to make changes as required against the audio recording. When I was satisfied with the copy, I edited out the utterances from the transcripts, so that participants were able to easily read their words and did not get 'stuck' reading patterns of their speech.

I then emailed the transcript to the participant indicating that they could amend, redact statements, or amplify their interview responses. Seven participants chose to edit their transcripts. Only one participant edited content, giving reasoning that it was not relevant to her experience in midwifery. Although, the content related to a family member's pregnancy, which she had used as an example of practitioner behaviour. Thus, transcripts were not sent back for reliability checking, as the recording was used against the transcript (Josselson & Hammack, 2021); rather, the process ensured participants could remove any elements that they considered contentious. Participants were advised they would not be anonymised, and their names would be used in the final theses. My intention, therefore, was to ensure that they were comfortable sharing the content. In group interview transcripts, individual participants only commented on their own account.

Transcription is part of the analysis process (Josselson & Hammack, 2021) and after listening to the interviews; while reviewing transcripts, I had a sense of initial narrative threads. Once I received the edited transcripts back from participants (one was sent in hard copy and had been handwritten on), I then re-read each transcript numerous times to further familiarise myself with its content (Lieblich et al., 1998).

While I reviewed transcripts, I listened to the audio recording. I was able to reflect on the biases or assumptions that became evident to me by listening to the interview. One assumption I had made was that clinical practices across the country would mostly be uniform. However, what became clear was that every hospital had interpreted evidence-based-practice in a different way; therefore, the hospital's clinical service was set up differently. For example, one hospital's protocol was that for admission in labour the patient required a medical indication. Labour, at any stage, was not a clinical indication for admission. Patients could choose to birth at a primary birthing

unit or at home. There was only one hospital in the country that maintained strict delineation between primary and secondary birth.

The transcriptions of participants' interviews varied in length between 12 and 65 pages, averaging 27 pages (single spaced), and between 8,500 and 35,600 words. In total, the transcripts amounted to 505 pages of raw data.

## 5.6 Narrative Analysis

I positioned myself as a co-constructionist within the research process to retain alignment with social constructionism. This means that reality has been socially constructed by both the researcher, the participants and the supervisors within the research process. Aspects of the co-construction process happened as a matter of course when discussing transcripts with my supervisors, additionally, using co-construction, I was able to incorporate participant feedback that was given to me when a few participants attended an online conference presentation I had given (see Page 66). Therefore, analysis of the narratives was an iterative process over several months of continued engagement. This extensive period with the participants' narratives allowed me to connect with the stories on a deeper level than initially gained through the interviews and first readings. Earthy and Cronin (2008) indicated that within the narrative analysis, the researcher considers both the content and form to develop interpretations of an interviewee's narrative. The analysis will also prompt questions like, "Why is the interviewee narrating this incident in this particular way?" and "What is the purpose of the story?" or "How does this excerpt fit with other parts of the interviewee's life story as narrated during the interview as a whole?" (Earthy & Cronin 2008, p. 8). The dataset was a vast amount of information that I needed to make sense of. I concluded that to manage this monumental task, I needed a formal set of approaches to assist me. There is not one identified best practice in analysing data in narrative inquiry and so I employed several key theorists to assist me in the analytical process.

Table 2 outlines the principal foci I adopted to analyse the data, and the key theorists used to inform my approach.

**Table 2** Narrative Analysis Steps and Authors

<b>Authors</b>	<b>Analytic Step</b>
Kim (2015)	Four stages; preparing the data, isolating individual units, data organisation, and data interpreting.
Riessman (2008)	A good narrative analysis “prompts the reader to think beyond the surface of a text, and there is a move toward a broader commentary” (p. 13).
Lieblich et al. (1998)	When listening to another’s story, researchers need to bring their own interpretation to the analysis: Categorical: experiences shared by a group of people (e.g., the process of migration) Content: “what happened, who participated” and “the meaning that the story conveys” (p. 12). Holistic: considers a participant’s whole intact narrative.
Bright & DuPreez (2023)	“The metanarrative may thus be seen as the story underneath the story that may be recognised in the narrator’s words, often with or without their awareness” (p. 12). Analytical “processes intertwine, connect and complement each other” (p. 43).
Connelly & Clandinin (2006)	Three analytical tools: temporality, sociality, place

### 5.6.1 Preparing the Data

Kim (2015) outlined four stages in narrative analysis, which I used early in the analysis journey to develop an initial understanding of the individual stories and later, as a collective. These steps included preparing the data, isolating individual units, data organisation, and data interpreting. Preparation allows the data to become malleable. Unravelling the narrative allows the researcher to develop their interpretation (Ntinda, 2019). Isolating data into individual units, characterises or groups important events about the phenomena. The third phase is an iterative process that I used to chronologically organise (temporality) and evaluate different components of data. In this stage, a researcher may identify a large group of previously isolated data that may have been deemed important but, when reviewed as a whole, is not considered relevant in relation to where the narrative has shifted. Thus, the process begins again. Finally, in the interpretation stage, associations across transcripts are drawn to understand the phenomena with deeper complexity.

When preparing the data, in the early stages of this process I isolated individual units and organised the data so that I may finally interpret the whole set. I initially used adjectives to describe participants' broad characteristics based on their personal attributes. For example, my notetaking regarding one participant reads, '*advocate, change-agent, truth/fact seeker, information-sharing, journey, questions-questions-questions- then trust, empowering, looks for solutions*'. These notes were simply for me to get a sense of who they were. I was not so interested in these participants' identities (Josselson, 2017), as much as I was interested in their experience. In essence, in this 'data preparation' I was making sense and identifying how individual participants had changed over the many years from what experiences they spoke about in interviews. I was also making sense of the changes in the midwifery profession over these years. I considered the main events, actions, people, and outcomes, and derived meanings from their stories. From this process, I captured a unique history which had not been previously identified on paper.

The findings chapters are presented using Lieblich et al.'s (1998) categorical-content mode of analysing narratives. It presents broader narrative categories which are not focused on specific individuals, rather the analysis occurs across participants' transcripts and looks at a collective or social group (i.e., sociality). This mode of analysis identifies how the collective group contributed to creating a cultural shift in childbirth and the whole maternity system within New Zealand. The findings also outline the factors that shaped the local midwifery profession over time, as told by the participants and as interpreted by me, the researcher.

#### **5.6.2 Four Modes of Narrative Analysis (Lieblich et al., 1998)**

Narrative researchers look for the finer details depicted within the narrative stories (Pinnegar & Daynes, 2007). Once I recognised that the larger narratives were more complex than anticipated, I drew on Lieblich et al.'s (1998) four modes of analysis when reading the narrative transcript and used story map grids to guide me in understanding the narratives, the metanarratives, and to assist in organising and analysing the narrative stories (Appendix E). The final story map grid aligns with chapter headings, subheadings, narrative threads, and research questions addressed in the chapters. These four modes of analysis are holistic-form, holistic-content, categorical form, and categorical content (Bright & DuPreez, 2023).

Although any one of these analytical tools has the potential to be used independently (Lieblich et al., 1998), I have used the four iteratively, as suggested by Bright and DuPreez (2023). Holistic-form and categorical-form consider aspects of plot structure, narrative style, and word selection (Bright & DuPreez, 2023). To further define these tools, the holistic approaches of narrative analysis consider the entire narrative while retaining an intact story. While categorical analysis segment the narratives, identifying sections roughly into categories.

Holistic-content and holistic-form together preserves the integrity of the narratives participant by deriving meaning from the entire narrative, while many parts of the narrative are interpreted (Lieblich, 1998).

All four analytical processes were organic in that they were happening at the same time and iteratively. As such, these “processes intertwine, connect and complement each other” (Bright & DuPreez, 2023, p. 43).

#### Holistic-form

The holistic-form of narrative analysis identifies how an individual constructs their own experience (Lieblich, 1998). Therefore, the researcher interprets the entire structure of the participant’s narratives individually. Initially, I selected the five consumer narratives to interpret their stories independently. To make sense of the vast dataset, I reasoned that organising the midwives’ and consumers’ experience separately made sense. I wanted to maximise my understanding of their own experience using their words and so I wrote a contextual synopsis which led into their narratives. However, it did not easily convey the temporality, sociality, and place as I had anticipated. Moreover, my interest was the collective experience of the creation and development of the midwifery profession, and this was not immediately evident in the style of presenting individual narratives.

#### Holistic-content

Holistic analysis explores a significant change within the context of a person’s life; for example, how the change in maternity system affected participants’ professional identity (Lieblich et al., 1998). I considered both the processes and its effects on participants in terms of their careers, career identities, wider society, and the

timeframe across 3-decades. Reading narratives through such an iterative process allowed me to view the transcripts holistically and categorically.

### Categorical form

Essentially, content analysis focuses on what has happened, and form concerns itself with how it has happened (Bleakley, 2005). However, a categorical analytical strategy breaks up the plot into categories to generate meaning. Categorical analysis is often considered an approach to be used when an experience has been shared by many individuals; for example, in this research, the process of changing the law.

In this phase I utilised NVivo software package to organise the transcripts into categories. Reading through them I noticed topics which could roughly be placed under similar headings. I gathered large sections from the transcripts and organised them into folders and subfolders. Some folders had more entries, such as 'pay/financials' with 118 quotes, as every participant discussed financial aspects in their interview. Another folder entitled 'adversarial treatment of midwives' included 78 individual transcript entries and was the second largest folder. I then broke these entries into subfolders within the larger folder, based on the participant's experience of being treated in an adversarial way. The subfolders were named after the profession or location where the adversarial treatment occurred— 'by doctors' and 'by midwives'. Within the subfolders I listed the events in chronological order so that immediately I could identify if a frequency of experiences gathered around a specific timeframe.

### Categorical content

The content focuses on the who, what, when, where, and why to understand the meaning of the story (Lieblich et al., 1998). The categorical-content mode of analysis included identifying, interpreting, and recognising narrative threads or patterns within the data to understand how the participants made sense in retelling their experiences (Lieblich et al., 1998).

While adhering to both categorical and holistic analysis, I highlighted text on the saved transcripts in different colours to differentiate when a participant discussed a common category such as midwifery education, practice, or another broad concept, which became evident across several transcripts. Then, I went back to the digital copies and compiled the categories using these broad ideas (see Appendix H for an example).

I paused audio to focus on note taking at certain points, with the participant's name, the date of listening, where I was, the quote, and my thoughts in that moment about what had been said. For example, one entry from my listening notebook says:

11 October 2023, Cornwall Park, Brenda – The babies belonged to the hospital..."

My note next to her quote expanded on my thinking about her comment;

The women also belonged to the hospital, if they didn't do what they were told (i.e., what they were 'supposed to do') they were labelled 'bad patient'.

(Women's place in society as exemplified in the hospital), relating to the critical feminist theory.

I was deliberate in my note taking as part of my initial analytical process when I listened to a recorded interview. In the early stages my notes were quotes from participants, Joy – "wanted to protect/availability of 'dream team' service". Over time, the notations progressed in depth. In one listening-note-taking episode of a consumer interview, I wrote on the note page, 'wanted women to understand their options around birth... implemented intentional protective strategies (at funding negotiations). Midwives = safety in numbers... transitioned into funding to help communities/"silent fighter" working from the inside'. As I continued to listen to the transcripts, my notations became fewer direct quotes and more indicative of the broader context to understand the overall narrative story, and then the underlying story or the metanarrative (Bright & DuPreez, 2023).

I kept a separate field notebook which included participants' initials and dates and when I revisited the interviews. On one occasion, I wrote a direct quote from the audio and then extended my thinking about what the participant had said. 'BH: "we can guarantee you a live baby" and next to this in my field notes, my rudimentary extension was, 'but at what cost to the mother? The mother's desires [patient] do not seem to be a focus within the maternity system. Or are they?'

The categorical-content approach enabled me to look at groupings of categories by isolating segments of stories as indicated by Lieblich et al. (1998). In dismantling these segments, I was able to analyse across several interviews, while at the same time

remaining cognisant of the holistic narrative presented within one participant's story. Participants who shared a common experience around a specific timeframe and/or place allowed a commonality to easily stand out. For example, participants discussing where they were when the Act passed in Parliament. Here I was able to gather more complexities within the formal and functional structure of the narrative by bringing the threads of participants' stories together in the metanarrative. For example, in considering the effect of the Act holistically, I considered the significance and change on participants' careers or access to options in childbirth (Earthy & Cronin, 2008). However, viewing this categorically, I considered participants' narratives as they discussed their lives before and after the Act passed. Although they may not have explicitly named the event, because I was considering this holistically, I understood it in view of their larger story (Lieblich et al., 1998). On reflection, I do not believe that the required depth of analysis was present.

#### Iterative nature of narrative analysis

Feeling somewhat adrift after the amount of critical thinking and data organising, I realised that I would need to perform further analysis and recognised the value of the iterative nature of the analysis process. I returned to the data and focused on what was being said by individuals. I took a chronological (temporal) approach to the data to contextualise the timeframe leading up to the activist movement. Thus, through the consumers' experience, the reader could get a sense of the relationship between the participants, midwives, and consumers to understand why consumers were so motivated in their support of midwives.

In narrative inquiry, transcript interpretation preserves the story events as threads and extends the accounts to be woven into a broader narrative (Riessman, 2008). Narrative analysis centres the storyteller, their perception and interpretation of the story (Riley & Hawe, 2005). During the process of analysis and transcript interpretation, considering several of the participants' experiences (Pinnegar & Daynes, 2007), I was able to recognise the whole of the story as many threads weaving across and gain understanding in terms of temporal, spatial, and contextual themes (Connelly & Clandinin, 2006).

The unravelling or deconstruction of narrative provides deeper understanding, so the researcher does not simply accept the words as they have been stated (Kim, 2015). I noticed amongst the wide collection of narratives there were commonalities in the way that participants discussed a shift in the increase of technology over time; for example, ultrasound scanning. I understood this to indicate the importance for participants as a comparison of 'then' versus 'now' underscoring a temporal aspect of social change. By using the formal and functional together in the interpretation, I was able to grasp participants' viewpoints compared with the dominant medically minded social narrative. Individually, participants expressed how, in the absence of strong clinical evidence supporting the use of ultrasounds, there has been an increase in practice management and therefore social expectation for the increase in ultrasound scanning over the last 30-years.

To make sense of the wider narratives, I organised the threads in a chronological fashion. I had gathered all the data from my notes and participants' transcripts, along with my interpretations. Participants spoke about belonging to the home birth community and the collective professional pathway over time. Repeated familiarisation and continued engagement with transcripts were part of the iterative process and assisted in developing the deeper complexities within the story (Braun & Clarke, 2013). To stay engaged with the participants' narratives, I would listen to the interviews when driving alone or walking to work. This continued engagement gave me insights into the stories over time and allowed me to listen to multiple interviews closer together than when I performed the interviews. I was able to stay engaged with the participants' stories when I did not have the time to sit and read through interview transcripts.

Organising the data chronologically (temporality) allowed me to more easily categorise the data using the methodological frames of temporality, sociality, and place (Connelly & Clandinin, 2006). It further allowed me to remain mindful of inductive and data driven themes, rather than imposing a hypothesis and my own presuppositions. The primary aim of the analysis was not to concretely focus on what the participants said, as one might expect in a thematic or discourse analysis (Braun & Clarke, 2013); rather, to allow me to better understand the deeper complexities of participants' experiences

through their collective narratives (Sharp et al., 2019). I also employed the use of story map grids to organise the chronological analysis (see Appendix E).

### 5.6.3 Narrative Tools

Within this narrative inquiry, I applied the elements of temporality, sociality, and place (Connelly & Clandinin, 2006) to organise narratives into relatable and meaningful stories, and to provide a narrative thread across the findings chapters. This research situates my inquiry within the concept of “temporal transition” (Clandinin & Huber, 2010, p. 479), encompassing the past through to the present as represented in the participants’ core narratives. By contextualising the findings within these temporal markers, I examine how events have unfolded over time, drawing on participants’ experiences as they account for changes in midwifery over time.

Sociality is defined as the social and personal conditions or “feelings, hopes, desires, aesthetic reactions and moral dispositions” (Connelly & Clandinin, 2006, p. 480) of the participants. As well as considering the social conditions of the events that unfold, such as the cultural, institutional, and linguistic aspects of the stories, a further dimension of sociality effectively considers the researcher’s and participants’ lives (Clandinin & Huber, 2010). As previously stated, the narrative inquirer (myself) cannot be divorced from the inquiry. Throughout the analysis, I have used sociality to examine what participants identified as their hopes and desires over the course of their careers and compared these collective aspirations to the historical accounts of what did transpire over time.

Place, in this research, is defined as, “the specific concrete, physical and topological boundaries” (Connelly & Clandinin, 2006, p. 480) or where specific events took place, including the interviews and participants’ residential locations. In terms of how it was interpreted in the analysis, the inquiry is set within major cities in New Zealand and across both islands. The context setting is an insular nation at the bottom of the Southern Hemisphere. As a colonised nation, the elements of temporality, sociality, and place, recognise the Indigenous Māori people and Te Tiriti o Waitangi within the context of this research. To add a further layer to the definition of ‘place’, as used in the analysis and interpretation of participants’ stories, place also considers birth-place (i.e., home or hospital, primary birthing unit or tertiary facility). While place, in effect,

identifies New Zealand and attempts to understand the context of what that means in terms of the wider world, there is another more simplistic view of place within the research context of where birth events happen within the stories.

Temporality, sociality, and place are tools that have been used to unravel, unpack, and interpret the narratives to analyse the events as told by participants. They are outlined in more detail below.

### 5.6.3.1 Temporality

Within narrative inquiry, temporality refers to having a linear relationship with actual time—past, present, and future. Within this research, I have utilised temporality to situate the story within a specific timeframe, with a beginning and end, to contextualise events for the participants, myself, and the audience. Identifying narratives from these structured time points helps ground the events of a story within a set context (Connelly & Clandinin, 2006).

While narrating the story, temporality provides a mechanism of hindsight for an additional layer in the retelling (Kim, 2015). In addition, temporality was used within the chronological analysis to compare the contrasting social changes within New Zealand, as told through the participants' narratives. Participants discussed how in the 1970s, midwives were subsumed under the medical system and the word 'midwife' was obsolete, while people were well acquainted with the terms nurse and doctor. In progressing participants' goals, by re-introducing the word 'midwife' into New Zealand vernacular, temporality and sociality are used to timestamp and recognise the moment that these stories are set, and to identify the effects on participants and wider culture.

Temporality, along with sociality and place, identify the changes where midwifery was once inaccessible in the 1970s compared with 2023, when midwives were the practitioner majority. The participants' collective accounts illustrate the conditions which necessitated a cultural and social shift within the maternity services from physician-led toward a midwifery-led model, and identify how these events occurred over time. This thesis captures, analyses, and relays the collective narratives, and outlines society's notion of childbirth over these decades.

### 5.6.3.2 Sociality

Broadly speaking, alongside temporality and place, sociality has been utilised to analyse the data and considers both the personal narrative and the social conditions of the events and experiences (Clandinin & Huber, 2010). Sociality refers to the social conditions surrounding the participants' experiences and the stories they choose to bring into their narrative. As the researcher, I remain cognisant of the stories which are selected for analysis (Clandinin & Huber, 2010). Describing events within the larger social context broadens the personal narrative from an individual sharing one account of events to a larger historical context (Connelly & Clandinin, 1990). As this research is set within a historical context, with a series of events resulting from the participants' actions, namely changing the maternity system, it makes sense to incorporate tools such as sociality, place, and temporality in the analysis.

Sociality or social conditions represent the conditions under which people's experiences and events are unfolding and therefore are presented within their linguistic narratives (Connelly & Clandinin, 2006). A further dimension of sociality is recognised at the apex between research and participant interaction. Thus, as the researcher, I attempted to convey the personal characteristics "feelings, hopes, desires, aesthetic reactions and moral dispositions" (Connelly and Clandinin, 2006, p.480) of participants through the analysing of their narratives.

### 5.6.3.3 Place

Place is used within the analysis of the inquiry to outline how the environment, where events happened, affected participants' narratives. The areas where the participants lived, rural or urban, influenced access to services and availability of resources. Specific locations outlined in narratives, such as birth in hospital or at home, shaped experiences (Connelly & Clandinin, 2006). Additionally, identifying place in the analysis contributes to understanding the backdrop for an event and, therefore, contextualises the outcomes of stories (Lieblich et al., 1998). This inquiry is set within New Zealand, which encapsulates Te Tiriti o Waitangi and the historical events of colonisation (Nursing Council, 1996). As such Te Tiriti o Waitangi has relevance with regards to 'place' with regards to understanding the historical events surrounding birth locally (Berghan et al., 2017).

The place in which the narrative occurs is significant, particularly the socio-cultural and political context specific to New Zealand. It would be ethically remiss of me, as a New Zealand researcher, to exclude further detail of place in this study.

#### 5.6.4 Te Tiriti o Waitangi as Related to Place

Te Tiriti o Waitangi, or the English translation, the Treaty of Waitangi, in the context of New Zealand, is a colonial agreement with the British Crown and the Indigenous Māori people of the country. The document was signed in 1840 by Captain William Hobson, some English residents, and between 43 and 46 Māori rangatira. Soon after signing, the two separate translated documents—one in Te Reo Māori and one in English—were noted to have incorrect translations in key areas. These incorrect translated documents have since caused a divisive union (Berghan et al., 2017).

The study participants identify as pākehā and Tangata Tiriti (white and non-Māori). Te Tiriti establishes obligations for all New Zealanders, including conducting research; therefore, all principles relate to all people—both tangata whenua, people of this land, Māori; and Tangata Tiriti, those that have come to New Zealand later than Māori (Wepa, 2015).

What is key is appreciating that research taking place within New Zealand should reflect obligations to Te Tiriti o Waitangi (Hudson et al., 2010) and assist in realising Māori health aspirations. As a researcher within the context of New Zealand, I was mindful of Te Tiriti obligations and have applied the Articles of Te Tiriti, namely Kāwanatanga, Tino Rangatiratanga, Ōritetanga, Wairuatanga, and Tikanga, in the research development and procedures. As most of the participants identify as pākehā, this research shared Te Tiriti obligations with the participants to understand, from their perspective, how these Articles, and by extension Te Tiriti, have come to shape modern local midwifery service.

##### 5.6.4.1 Kāwanatanga

Kāwanatanga was originally interpreted as informing pākehā of the right to co-exist in New Zealand under governance of the Crown. However, for research purposes, kāwanatanga reflects engaging in whanaungatanga; meaning for the researcher to actively build relationships and act in a culturally respectful and appropriate manner. It includes practicing humility and not speaking for Māori people (Berghan et al., 2017).

In a practical sense, kāwanatanga was demonstrated when interacting and engaging with participants during interviews. It entailed maintaining professional and considerate behaviour, honouring and being respectful of relationships throughout the research and dissemination.

#### 5.6.4.2 Tino Rangatiratanga

Tino rangatiratanga is understood as Māori self-determination or personal autonomy. It has been reflected throughout the research process by ensuring Māori-led or participant-led processes. Practically, it was interpreted by sharing in the power dynamic between researcher and participant. Participants dictated location and duration of interviews, and involvement of other participants (e.g., the group interviews). Participants were encouraged to review their transcripts to advise what material would be available in final reports. Another practical interpretation of tino rangatiratanga was in gleaning participants' understandings around how Māori self-determination had been implemented within the profession from 1990 for wāhine Māori and/or Māori midwives.

#### 5.6.4.3 Ōritetanga

Ōritetanga is traditionally understood to mean equity for Māori (Stevenson, Filoche, & Lawton, 2020). It was demonstrated in the research by identifying the specific actions within midwifery to ensure equitable maternity outcomes for Māori. Discussing Te Tiriti obligations with participants created reflection opportunities for participants around their views of how Māori health equity was prioritised.

#### 5.6.4.4 Wairuatanga

For the purpose of this research, wairuatanga means cultural and religious freedom. I have interpreted the meaning as ensuring Māori worldviews and values are upheld. Practically, it was reflected with participants as we discussed how traditional cultural freedoms have been upheld within midwifery practices over the period this research covers.

#### 5.6.4.5 Tikanga

Tikanga are considered appropriate Māori customary practices or behaviours. In research, this translates to Māori values and ethics (Hudson et al., 2010). Although specific tikanga customs may differ between iwi and hapu (tribes and larger groups of

family structures), the intention is to enhance relationships to preserve mana between research and participants. In practice it was exemplified as reciprocity of power. Participants were viewed as experts in their experience and in the re-telling of their own narrative. They were placed in equal position to the researcher whenever possible, in interviewing them on their 'turf' and outlining expectations.

Tikanga could also be viewed in the perspective of collecting and maintaining ethical procedures and values throughout the research process. One example of upholding tikanga was expressed in gaining ethical approval from AUTECH as standard cultural practice. Another example was the way I commenced interviews with a detailed introduction of who I was. Elements of the ethical processes include informed consent, recruitment, and benefit to the wider community. The practical steps taken in the ethical process is further described in section 5.3.

## 5.7 Limitations of Narrative Research

I have undertaken this narrative research to communicate an inquiry around the human condition (Polkinghorne, 2007). Narrative inquiry presents claims about lives, how individuals understand the world, each other, and themselves. There are noted criticisms of narrative inquiry, including a lack of trustworthiness of the data as life stories change over time (Polkinghorne, 1988) which may change participants' perspective of past events. Murray (2009) suggested that because the researcher selects the questions, there is a danger that the interview may focus on the researcher's perspective of importance rather than what the participant regards as important. To mitigate the focus on what I perceived to be of importance, and to minimise my authority within the research process, I did several things. I deliberately used a series of open-ended questions, so that participants could direct the path of the interview. I was flexible with participants proposing group interviews. I made attempts to let them select the interview location, often meeting at their home and/or workplaces so that they were in a familiar setting, and I was the guest. In my introduction to participants, I intentionally disclosed that I was a direct-entry homebirth midwife, and had both my children at home as planned; therefore, I had a shared understanding of having been a home birth practitioner and a home birth

consumer which aligns with the line of inquiry. I was fortunate that the participants were willing to share so openly.

Another criticism of narrative inquiry is regarding an 'accuracy' in relaying stories. Critics have indicated that 'remembered facts' are different from a 'historical truth' (Lieblich et al., 1998). However, I consider this to be an advantage. My interest in the inquiry sits within the narrator's experience and perspective, and I have considered the available historical events alongside participant recollections. Furthermore, recorded historical 'facts' are only as good as the storyteller has recalled the events. As a researcher, my interest is in how the events impacted the participant's life, because these achievements are absent from New Zealand's written history. Therefore, it is not known within the general knowledge base.

## 5.8 Rigour in Narrative Research

The purpose of rigour in narrative research is to provide readers the confidence of trustworthy research methods (Polkinghorne, 2007). Narrative storytelling has been the primary mode for transmission of knowledge passing down oral traditions, experienced wisdom, fables and fairytales, throughout generations and cultures (Spector-Mersel, 2010). Stories focused on childbirth, doulas, and midwives are some of the oldest stories women have shared (Barnawi, Richter & Habib, 2013). Therefore, narrative inquiry, as a research methodology, has deep epistemological roots. Further, because individuals understand themselves in interpretive and socially and culturally constructed processes (Spector-Mersel, 2010), their attempts to garner knowledge is through composed stories (Riessman, 2008).

Narrative inquiry prioritises subjectivity to uncover the lived experience (Josselson & Hammack, 2021), and while stories offer examples for learning, as in fables, so too these "stories do not belong to an individual; once spoken, they are shared" (Crowther et al., 2017, p. 843). The co-construction aspect of narrative research is rigorous and develops through the relational process (Clandinin, 2006) of the sharing of connections between researcher and participants; and, additionally, between myself and my supervisors during research discussion meetings (Arvay, 2003). The iterative procedure of analysis allowed for deeper interpretation (Bright & Du Preez, 2023; Lieblich et al., 1998), and re-storying ensured that the participant voices were heard while the

meaning was contextualised within the broader line of inquiry (Atkinson, 2007). As this narrative inquiry considers the societal and temporal exploration of changes over a significant amount of time, there are several elements which have been considered within the analysis.

Additionally, the participants' experiences are varied from working in government, clinical practice, midwifery governance, and education. They were able to bring a broad and reflective understanding to their own experience prior to interviews. The rigour of this narrative inquiry is further strengthened by the level of education amongst participants; many hold postgraduate qualifications and over half have PhDs. Their advanced education, coupled with their clinical experience, mean they are well-versed in critical reflection, clinical assessment, seeking and transmitting knowledge. Their skills align with the core tenets of rigorous qualitative research. Their ability to articulate their experiences, which they have no doubt previously analysed within broader structural contexts, enhances the depth and reflexivity of their narratives, and that of the dataset itself. Their collective background ensures that these stories are not merely anecdotal but informed by professional scrutiny; therefore, making them valuable sources of knowledge production in this line of inquiry.

To ensure rigour within the thesis, I employed an iterative process of reviewing the transcripts coupled with engaging with the audio interviews and note taking. Additionally, participants reviewed and edited their transcripts for clarification or retractions. For thoroughness, I engaged in several in-depth discussions with my supervisors alongside each phase of analysis involving initial broad narrative categories, searching for dominant narratives, and scouring for counter narratives. I used a self-reflexivity practice as a process for thinking and scrutinising actions, or inactions, in specific situations (Thompson & Pascal 2012). I also engaged in a reflexive practice which included steps of self-analysis to uphold my professional knowledge. My actions were consistent with my profession's values, and I applied the opportunities for learning and development (Gao, 2013; Thompson & Pascal 2012). Throughout the research process, I used Elliott's (2005) proposed questions:

- What do I notice?
- Why do I notice what I noticed?
- How do I interpret what I noticed?

- How can I know that my interpretation is the correct one?

Using these reflexive questions guided me to become more aware of my place within the research and step away from the material before coming back to the analysis.

Individuals use their narratives to construct their own reality (Josselson, 2013), which was evident in the narratives shared. Had I chosen to interview a different selection of participants, the research would present different, perhaps even opposing, findings.

### Trustworthiness and Credibility

Riessman (1993) argues that the credibility of narrative analysis begins with the researcher's explicit recognition that interpretation is inevitably shaped by particular discursive positions and theoretical orientations. Such acknowledgement allows the researcher to move beyond conventional notions of validity grounded in realist assumptions, and to accept that alternative frameworks may generate different; but equally legitimate; readings of the same narratives. In this view, the aim is not to claim an objective or universal 'truth', but to demonstrate trustworthiness through transparency of process. What becomes central, then, is a clear account of how interpretations were constructed, the theoretical lenses employed, and the analytic decisions made along the way. By rendering these visible in my study, my resulting analysis can be understood as credible and trustworthy, not because it represents truth in any absolute sense, but because it makes evident the rigour and reflexivity underpinning its construction.

To strengthen the credibility of qualitative research, triangulation is often employed through the use of multiple forms and sources of data. By drawing on diverse materials and perspectives, I was able to illuminate recurring themes or patterns from different vantage points, allowing for a more layered and comprehensive understanding of the phenomenon under study (Creswell, 1998). In addition, credibility was enhanced through member checking, a process in which participants are invited to reflect upon and comment on the researcher's interpretations and findings. This dialogue between myself and participant is widely regarded as one of the most important strategies for establishing the trustworthiness of a study (Lincoln & Guba, 1985; Miles & Huberman, 1994).

Understanding participants' narratives, however, cannot occur in isolation from the social, cultural, and institutional contexts that shape their experiences. Human actions and reflections are situated within these wider environments, and it is only through attention to such contexts that the meanings embedded in participants' stories can be fully appreciated.

## 5.9 Conclusion

This chapter has described the narrative research methods I adopted. The participants are described, and methods around recruitment have been discussed, including ethical considerations. The purpose of narrative interview, transcription, and procedures of analysis have been justified with practical examples provided. The chapter concluded with a discussion of limitations and rigour of narrative research, and the ethical considerations specific to the New Zealand cultural context. I have shown how narrative inquiry, as both methodology and method, provided an optimal approach to my research. The narrative findings are presented throughout the next five chapters.

## Chapter 6 Findings: Narrative Category – The Early Years

*I really didn't enjoy being a hospital midwife. (Susan)*

The findings chapters are presented in chronological fashion, identifying the temporal transition of how participants' experiences were expressed over time (Connelly & Clandinin, 2006) covering the period between 1970s and 2023. Each findings chapter explores one of five narrative categories including: Learning, unlearning, and relearning; A practice shift, the 'othering' of independent midwives; Modern maternity; "med-ernity"; and Spread out and stick together. These narrative categories were constructed using Lieblich et al.'s (1998) categorical content mode of reading a narrative. Story map grids were used to guide the narrative analysis (Appendix E). Throughout the findings chapters, several metanarratives that reflect the narrative category of each findings chapter have been identified in participants' narratives.

The current findings chapter begins with the narrative category 'The Early Years' and identifies the context of childbirth over the time that participants became exposed to contrasting models of practice—the medical system and the domiciliary home birth approach. Metanarratives identified in analysing participants' transcripts outline the patriarchal structure and its historical impact and influence on maternity services in New Zealand.

In the early years, before the research timeline, larger hospitals appealed to women by marketing a 14-day 'rest' from their unpaid work at home after childbirth. In reinforcing traditional gender roles through maternity services, the patriarchal influence presents through the "pain-free seductive carrot" (Donley, 1998a, p. 10), alleviating labour pain through interventions which are only available at the hospital, rather than supporting women using traditional natural birthing processes. Incidentally, the model of embedded pain relief is inconsistent with most other areas of healthcare where women's pain is often under-recognised (Asif, Asif, Rahman, & Jaber, 2025), under diagnosed (Miller, 2018), and under treated (Becker, 2017); highlighting a disparity in pain management techniques and the patriarchal norms in maternity practices (Cahill, 2001). The participants were fighting to disrupt patriarchal norms by choosing to have births at home where the focus is on the birthing women's

needs, rather than in the hospital institution where the practice focus is on structured protocols and time mandates.

These contrasting approaches form a juxtaposition between a clinical, sterile, medicalised hospital birth environment which prioritised hospital procedures and the home birth environment where the family is included, and the mother, because the practitioner is visiting her home, the focused priority. This juxtaposition introduces the metanarrative of authoritative and controlling rigidity versus a model of collaboration and flexibility between these two birthing approaches.

This chapter begins by outlining midwife participants' experiences of working within the medical system. It presents a metanarrative that outlines their experiences of the dominant medical approaches to childbirth and identifies their rationale for operating outside the system. Through their work in the hospital, they began to recognise a different approach to birthing, prompting them to leave the hospital system in search of a new approach to birth.

The relationship between domiciliary midwives and GPs is presented next. Here, participants outline the attributes of a good doctor. This is followed by a discussion of the consumer and domiciliary midwife partnership. Overall, this chapter identifies the narrative that home birth meant more than 'birth at home'. It symbolised women's defiance and personal ownership of their bodies and their babies. It was a deliberate act of empowerment by the birth mother choosing to exert agency rather than passively accepting standard medicalised treatment at that time.

I asked participants how they came to practice midwifery and about their affiliation with the homebirth community. In collecting their stories, temporality, sociality, and place were used as a narrative thread to situate participants within the context of a time, the social conditions, and locations prior to midwives being autonomous. This context helped provide insight into participants' motivations to align themselves with what was seen by some as 'fringe' or 'hippie' or 'feminist'.

This chapter begins by outlining the standard hospital treatment and highlights how the institutionalised 'system' benefitted doctors at the detriment of both patients and midwives. The participants' narratives explain how developing home birth

communities were in support and empowerment of women. The community structure created frameworks for consciousness raising where participants improved health literacy within the wider population. It was through these communities that they were able to employ the political tactics where they developed the legal basis for the Act. The chapter ends with participants discussing the feminist movement, the relationships between consumers and domiciliary midwives, providing reasons for their activism, and outlining the change they wanted to make to health practices at that time.

## 6.1 Standard Medical Practice

Broadly speaking, since the genesis of birth in hospitals, delivery units were staffed with practitioners that performed tasks and patients had a passive role in their treatments. Nurses did not question their superiors and followed the orders they were given (Skiff, 2014). Obstetric nurses did not coddle patients or dote on the neonates. Rules were adhered to by all the women—nurses, midwives, and mothers. Patients did not request information about procedures of childbirth (Dobbie, 1990), despite often being fearful of treatments. Once the babies were born, they were taken to the nursery for bottle feeding, while mothers were taken to their postnatal room to recover.

*Epidural anaesthesia was available but it was it was hugely heavy you couldn't leave women on that were in the delivery rooms on those sort of theatre type beds, and you couldn't leave them because the anaesthetic was so dense if their leg fell off the bed they didn't know. And so and you had to stay with them until the feeling came back again that they could move their legs properly and you could sit them up without them fainting with the hypotension. (Jackie)*

Consenting procedures were not as we understand them today; thus, when medical or nursing students were rostered for clinical duties, they typically observed patients and performed set duties. Susan shares a memory from her nursing school experience, when labouring women shared a room and were taken to a delivery room when their birth was imminent. This was considered an efficient training method to involve all the nursing students at the same time.

*Where I trained, they were lined up [with] a curtain in-between and I had to pull down one woman, [she] was standing, holding the curtain*

*rail shrieking her head off. She was afraid and [it was] awful because they were hearing one another. For my first birth ever, they pulled all 30 of us in to watch. Standing at the end of the bed. I don't know that she ever got asked. (Susan)*

Susan's reflection that the patient had not been consulted exemplifies the culture within the hospital institution, an understanding that patients and nursing practitioners are not to question the rules of the hierarchy. Students and patients, both subordinates, both women, were expected to follow instructions; suggesting that the medical institution, and by extension the patriarchy, should not be questioned as it is the controlling and all-knowing enforcing power. Christine shares a story about when she worked in the hospital and how it was common for staff to observe patients without their knowledge or consent.

*At the [hospital] there were these windows, and you look through and see a woman from here down [indicating waist] in the birthing theatre. We would all just be really quiet, and we could just watch all these births. It wasn't a window with glass; it was just like an alcove. That was in the 70s. (Christine)*

This example of espionage, practitioners hiding, observing, outside birthing rooms, continues today and is outlined in later chapters. However, now it is the midwives who are the subjects of non-consensual surveillance.

Carolyn outlines routine hospital birth practices, noting, "what was seen then as good treatment". She recalls patients were so heavily medicated that they sometimes had no recollection of giving birth.

*It was rare to see someone who wasn't sedated. Primips were given diamorphine, which was pretty, pretty potent medication. It was given quite regularly from six to four hourly. I can remember one woman kind of rousing out of this stupor and she'd wound up having a forceps delivery, because of course they were too far gone to be able to push their babies out and flat on their back, legs in stirrups. [She was] patting her tummy and saying, 'oh, I've had the baby'. It's amazing that families managed to stick together through what was then seen as good treatment. (Carolyn)*

Standard hospital deliveries included regular doses of heavy medication, often because women were frightened. Medication was used to both calm and sedate women, leaving them semiconscious. The potency and regularity of medication obliged

practitioners to actively manage hospital deliveries. In Carolyn's recollection, the patient only becomes aware that she had the baby when looking down at her own body. She did not wake from her medically induced stupor because she heard the baby crying or others talking to the baby. The baby was in the nursery, not the recovery room with its mother. Separating mother and baby was the norm. It allowed women to 'rest' and rouse from the medications. Babies also needed to recover from the heavy doses of medication, and they were fed in the nursery because the mother was not able to breastfeed until the medication wore off.

Brenda, a consumer, shares her experience as a junior nursing student. She discusses the standard procedures that immediately followed hospital deliveries.

*At the time of birth, the baby was held up, she was shown her baby and then the baby was whisked off and because I was the junior nurse and not doing the whisking off, I could see the mother and the expression on those mothers' faces. I still remember it, that look of panic and fear like, 'Where are you taking my baby?' But by 1-week postnatally that was all gone, they had so little contact with their babies each day that they became disconnected from their babies... by the time they'd got to a week post-birth we'd have to kind of chivvy them out of the lounge to come and feed their babies. There was a real kind of disconnect because the baby didn't belong to them, it belonged to the hospital. (Brenda)*

Brenda's experiences validated for her that she was not willing to participate in this type of nursing work; she did not want to do the *whisking off* of babies, and so she did not complete her nurse training. What she did learn was that the hospital practices for childbirth did not align with her aspirations for birth. When she became pregnant, she was very intentional in choosing a domiciliary midwife because of her experience with the standard institutional practices. Brenda did not want her baby taken away and so chose an option that allowed her baby to belong to her, and not the institution.

This section outlines participants' experiences of routine hospital practices and procedures. Participant experiences identify the treatment that patients were subjected to without their consent. Participants describe the standard medical treatments at that time, expressing that they did not enjoy working within the medical institution.

Moving into the next section, participants continue questioning the standard medical practice. This questioning and reflection lead them to identify that, to work in alignment with their values, they needed to consider how and where they would practice. They chose to leave the institution to work as domiciliary midwives in the community. When reflecting on midwifery practice outside the hospital, they expressed feelings of freedom, talking about the potential for how birth ‘could be’ different for women, their families, the baby, and for themselves as practitioners.

## 6.2 Domiciliary Midwives and Home Births

*I said to Joan Donley before the Act, ‘Joan, I’d like to be a homebirth midwife, but I’ve never even seen one. Can I come out with you and see some home births?’ And she said, ‘Don’t be ridiculous, Joan just go and do it’. (Joan)*

In the New Zealand midwifery context, the adage ‘all roads lead to Rome’, could be ‘all roads lead to Joan’—as in Joan Donley. As more midwives considered attending home births around the 1970s, Carolyn, in 1973, was the first to leave the hospital, followed by Bronwen in 1974. They contacted Joan Donley to find out what they needed to do to set up practice (Banks, 2007). In the above quote, Joan Skinner indicates that she, like many other midwives, contacted Joan Donley. Although they had attended hospital deliveries for many years, they reported feeling ill-equipped to attend a normal delivery at home. Within this section participants explain how institutional practices made them afraid of childbirth. They did not have the skilled hands—they did not know what to ‘do’ or what tools to have with them when supporting birth at home. This form of practice required a very different set of skills.

The data presented in this chapter speak to both sociality and place as participants discuss the intentional shift in the birthing culture to regain control over their births and/or their home birth practices. Additionally, the data speak to place in that the chosen birth place was intentional—at home women had the continuity of a practitioner that knew them and would support their choices during the labour. One of the main drivers for these consumers and midwives to support women at home for birth was the philosophical belief that pregnancy and childbirth is a normal phase in reproductive health, and a hospital is a place for the infirm to obtain treatment and medical care. Pregnant women required specialist care from someone that specialised

in physiological childbirth and infant care. Domiciliary midwives also reported recognising an element of freedom when attending home births; they were governed by a different set of professional ethics which centred around the woman and her family.

Bronwen discusses how domiciliary midwifery was still legal under public health statutes and became revived through Joan Donley.

*So, what happened is, all the midwives between 1930 and 1970, they all died out and by then everything was happening in a hospital. There was only one or two people probably still claiming those fees and that's what Joan Donley found out about. She knew the midwife in Auckland who was still working and so she decided that was the way for her to go. Then she convinced Carolyn Young to join her and so it was just an interesting time. Then because she'd done that, other people set up in practice. (Bronwen)*

Access to homebirth was limited for women because only a few domiciliary midwives were practicing around the country. To ensure the option of a homebirth, women would contact midwives before they were even pregnant.

*It wasn't accessible in the 1980s. We had a woman contacting these midwives saying, 'I'm going to be pregnant next month, are you available?' They were booking their midwife before they got pregnant. 'I'll ring you and confirm when I have a positive pregnancy test but put my name down for May'. (Brenda)*

Brenda further expresses the reasons that prompted the home birth community into activism. She describes why domiciliary midwifery was not a viable profession and was, therefore, inaccessible for women across the country.

*We felt that if midwives could be autonomous, because that was the other issue for home birth, the women not only had to find a midwife they had to find a doctor as well. But if the midwives could be autonomous, then that would make home birth more accessible. And if midwives were paid properly, domiciliary midwives weren't even paid properly... it had sort of accidentally stayed on the statutes since the 1930s the payment schedule had never been updated... [Social Security Act 1938] in 1974 there had been a number of domiciliary midwives but most of them had to take time out and work at hospitals, basically just make ends meet... Carolyn was a single mum and could have made more just being on the DPB [domestic purposes benefit], then she did as a domiciliary midwife. (Brenda)*

Brenda and Joan Donley worked together in a bookstore. Joan supplemented her income because midwifery alone did not earn her a sustainable income.

*...those days domiciliary midwives were so poorly paid that she had to have a second income. (Brenda)*

Brenda elaborates that the relationship between the women, midwives, trust, and belief in the body went beyond the financial incentives for domiciliary midwives. Although, she alludes to the non-monetary reward for midwives and families to be operating 'outside the system', she is referring to the surveillance and enforced rules which operate inside the institutional walls.

*You're always more nimble when you're outside the system. You're always more individualistic. So, we had midwives initially, who weren't really in it for the money, and the cost of living wasn't so high, and who also were prepared to go an extra mile in terms of accepting risk and trusting women's self-knowledge. (Brenda)*

Sian describes the pay rates from the 1930s. Although, she also touches on the relationships (discussed later in the chapter), she highlights a perk that the domiciliary midwives discovered about financial reimbursements available to them for driving to appointments, which the doctors had been claiming.

*From 1980 to 1990 I had been doing home births and there was a core group of us in Auckland with GPs who were very supportive. There were a few that would be there in name only. Over that decade there were women that you looked after repeatedly. Even though you saw the woman only three times antenatally, which is what you were paid for, three antenatal visits at \$4.50 per visit, \$25 for the birth and \$5 for the postnatal visit. But you made quite a bit on the public service mileage rates. You would get to know those [women] really well and get to know their families and so you would do repeats. They would often say, 'Oh, do we have to call the doctor?' and your relationship was probably the stronger one. That was in Auckland and [for] Bronwen there were no GPs. So Bronwen was already practicing outside of, I suppose the rules, because she wasn't getting signed off. That was ridiculous which was another reason for [Helen Clark] to put the legislation in place. (Sian)*

The only way for women to know the person who would attend their birth was to have a home birth. Domiciliary midwives had to establish a relationship with the woman over three visits. The appointments usually lasted an hour, so midwives would earn a

total sum of \$13.50. When women went into labour, the midwives were called. Regardless of the length of time the midwives spent attending labour, they were reimbursed \$25. GPs were paid \$75, whether they attended or not, because their names were required to be listed on the notice of birth as the practitioner responsible. As Sian indicated, it mainly depended on if the labouring women wanted to ring them. In some areas, GPs would not work with midwives. Sian mentioned that Bronwen was already challenging the status quo, simply because there were no doctors willing to be involved.

Below Carolyn shares how she met Joan Donley, which led her to question the medical institution. She discusses how the matron attempted to draw Carolyn into surveillance of her colleague, and how, instead, she aligned with Joan and chose to attend home births.

*Joan Donley and I were good friends, and we were both really questioning the way that birth happened in the institution. There was no home birth option, there was just Vera in her early 80s, and she was sort of hanging in and doing the odd homebirth. Joan used to work with me at Waitakere [hospital], I was actually her boss. I can remember matron taking me aside and said, 'Keep an eye on that one'. Joan was a bit of a stroppy tart, and for 50 years I kept a good eye on her and liked what I saw. So, it was Joan who, working at the hospital said, 'Someone's just had a baby at home and they're trying to drag her to the hospital. Why don't you whip around and offer her home care'. So, I did and I'm still good friends with that woman. She hadn't gone into hospital deliberately. She had a baby in the bath because she didn't want to go in and get ordered around, like all the women were ordered around. That's where the absolute love of midwifery happened for me. Going to a birth with Vera in the middle of the night and just seeing such a wonderful family-orientated birth and coming away thinking, 'What are we doing wrong? What have we done to change this into what I've seen for all this time?' And that's where it fell into place for me. (Carolyn)*

Carolyn describes the hospital working conditions, the attitude of the matron, working alongside Joan, and compares Joan's attitude to that of the hospital. The matron, attempting to recruit Carolyn into surveillance, to 'keep an eye' on Joan, was a common tactic within institutions to monitor and control behaviour, keeping women and midwives 'in line'. Carolyn recounts a home visit of a woman who, seeking to avoid being 'ordered around' by hospital staff, chose to freebirth, delivering her baby at

home without a healthcare practitioner present. These experiences led Carolyn to question her own involvement in hospital practices and how things could be different. When Carolyn mentions Vera, she does not discuss a GP being present. Although many domiciliary midwives reported working well alongside GPs, at other times the relationship was not described as collegial.

### 6.3 Relationships Between GPs, Domiciliary Midwives, and Consumers

*The doctor didn't get to the first birth; he was too late. It was very pleasing, but he would have been alright anyway. He was the kind of person that was relaxed and stood around with his hands in his pockets. (Glenys)*

When participants spoke about their relationships with GPs, they used adjectives such as great, good, collegial, fraught, and obstructive. Overall, positively viewed GPs were those who did not interfere in the labour, or the birth; or chose not to attend the home birth at all. Participants outlined the attributes which made up a 'good' GP who attended home births, as Glenys has mentioned. There was some irony in what midwives expressed as constituting a good GP since these characteristics included showing up and doing nothing, sitting in the corner with their hands in their pockets, or not attending at all.

Most labours were managed by midwives either in the hospital or at home, and when the birth was imminent the midwife called the doctor. In some areas around New Zealand, there were GPs who regularly attended home births, and these GPs maintained good relationships with midwives and women and were spoken of highly, by participants. These GPs were seen as different because they considered labour to be a normal phase in their patient's reproductive health, and so labour and birth was within their scope of primary health care.

Participants, however, also reported that some GPs did not enjoy attending births generally, regardless of the birth location. Those GPs offered alternative solutions.

*They refer [patients] to a colleague and had an arrangement with that colleague that he would return them to the original GP after the birth. The doctors didn't want to lose what was going to become two clients. They didn't want women shopping around independently and finding a GP who did provide maternity care. They gate-kept to make*

*sure that those women, post pregnancy with their babies, came back to them, it was all very strategic. (Brenda)*

Participants outlined some GPs hand-off approach towards home births. Carolyn describes the work being lucrative although not all GPs wanted to attend births.

*They walked in for an hour or even missed the birth completely and picked up the payment for the birth fee which, if you had only done a quarter of an hour's work, it was a very generous payment. It was quite a lucrative business but from my experience way, way back working in the hospital I don't know that all GPs enjoyed birth. They did it because it was part of looking after their practice and I think a lot of them were probably a bit fearful of birth too. It's like get in and get out. (Carolyn)*

GPs were paid a birthing fee and claimed for the fee when they did not attend the birth. Participants described this as being there in 'name only'. Karen elaborates,

*Being a midwife in those days, it was like you were just not there. You've spent all those hours, done all that stuff and, 'Thank you, doctor. You've done so much. Here's a bottle of champagne'. I remember one time they had a card and bottle of champagne ready for the GP. And the GP honestly would have been there for 5-minutes. And we used to say things like, 'If women don't feel the need to thank you it means you've done a good job'. But actually, that was really silly, we shouldn't have said that. (Karen)*

In some cases, in the days of the domiciliary midwife, the doctor, who was the practitioner responsible and the financial earner, despite not having attended, was seen as the person to be grateful to. Karen, in hindsight, identified that in order for midwives to feel valued, they adopted a mechanism of dismissiveness to counter not having been rewarded with minor gratitude or perhaps a gift.

Carolyn outlines the distinction between the supportive GPs who attended birth as part of their practice.

*The GPs were dedicated. The home birth GPs who offered care, who were exceptionally giving of themselves and the quality of care, [they] had just as much of a vested interest in getting birth back to normal as the midwives and the women had. But not so much the GPs that just built it into their practice and would come in at the actual moment of birth, in the hospital. (Carolyn)*

Historically, labour, regardless of the location, has always been managed by midwives and obstetric nurses who notified doctors when the birth was imminent, or earlier if medically indicated. This may have been how GPs rationalised collecting payments for the midwife's work, when they did not attend the birth.

*In Auckland there were quite a few GPs. So when women, say they'd have shared care, and the GPs turned up for the birth, sometimes they'd end up in name only. But most of the time they were a better ally for us than the midwives working in hospital. (Sian)*

Regardless of the location, midwives had always managed labour, when the attendance of the doctor was required, it was at the midwives' discretion they were called. Some domiciliary midwives reported being proud of ringing the doctor too late for a variety of reasons. After all, doctors did not attend labour, they attended the birth.

*The home birth midwives are out there and yes there might be a doctor's name on a piece of paper and a lot of it was about showing that midwives were making the decisions because the doctors left standing orders. So, midwives were actually running the whole show, and the doctors only came in to catch the baby or to miss catching the baby, and midwives were working under their own responsibility, except they didn't have it in the law. (Bronwen)*

At the time of domiciliary midwives, the GP service was inclusive of birth. Thus, a GP working with nurses and midwives was the standard arrangement. Midwives discussed having good collegial relationships with GPs when they considered home birth primary care and an extension of their practice.

*Auckland Homebirth and the doctor's group met regularly and there were four women GPs. They were great and there were really good relationships, until 1993 when all of a sudden you were competing for the same dollar. So, when the birth fee had to be split, then that made things incredibly difficult. (Sian)*

Sian describes the collegiality between the domiciliary midwives and the home birth GPs as 'really good'. As she continues, there is foreshadowing (further outlined in Chapter 10) of financial implications wherein the Act forced midwives into the role of an equally paid colleague providing maternity services, rather than the traditional subordinate role to the doctor.

Marjet, a consumer, describes the relationship between her GP and her domiciliary midwife, Joan Donley, over the course of her pregnancies.

*[I had a] very nice home birth, it was 12 or 15-hours, I don't remember. My husband was there, and we just got on with it. I do remember that John Hilton came on time for that, but for the other babies, all of which you needed to have a doctor for, he didn't turn up. He just said, 'Oh Joan, knows what she's doing'. He had 100% confidence in the midwives that were caring for me. My memory is that he was there for the first birth, he wasn't there for the others and that suited Joan down to the ground. (Marjet)*

Marjet mentions that her husband was present at the birth. In 1984, when Marjet's first baby was born, New Zealand hospitals did not allow husbands in delivery rooms. Husbands were not able to 'support' a labouring woman who was semi-conscious. They reportedly 'got in the way' and practitioners did not want to have to focus on a father who might faint (Skiff, 2014). Fathers were only allowed in the delivery room if they had met the hospital superintendent in advance and they needed to provide a written letter advising the husband was allowed entry when the mother was admitted in labour. The letter outlined that the father needed to follow the medical team's instructions, which included only standing near the mother's shoulders, and they needed to leave at any time if asked by the staff. The only way to ensure that a father would not miss the birth of their child was to have a domiciliary midwife at home. Carolyn remarks that the medical team in hospitals kept the fathers 'pretty voiceless.'

*Fathers had to be interviewed by matron, and she would decide if she felt you were up to scratch and you had to definitely stand at the head end, no looking down that other end, 'you dirty man', and so mainly they would behave. They knew the rules, that they stood at the head-end and if they were asked to leave, they had to leave, but basically pretty voiceless. So yes, with reluctance [they attended], but they weren't allowed to hold their babies. (Carolyn)*

In contrast, domiciliary midwives who attended home births alone, relied on the presence of husbands or older children. It was the husband who often rang the GP to advise them it was time to come. Bronwen talks about how midwives were practiced in the skill of 'managing the doctor's presence'. Hospital midwives would ring the doctor to show up when birth was imminent, or complications arose; similarly, domiciliary midwives also required the skills of diplomatically liaising with doctors.

*And of course, they got paid to come. And they got paid whether they came or not actually, which is pretty interesting. And midwives were quite proud of managing the doctor's presence at birth by calling them too late or whatever, when they could see that everything was normal, and they didn't want some doctor coming in and intervening and doing things that weren't necessary. There was certainly an element of that, and there was only one doctor really, who didn't come or always came after the birth. He wasn't interested in the birth because I think he was frightened. He was an older GP and eventually retired. The other ones came, or you'd call them and say, 'Look this birth is imminent, you could come or not come, up to you', and so you give them that. (Bronwen)*

Carolyn outlines how one GP attempted to intimidate a pregnant woman and her midwife. This is an example of how medical professionals use patient nudging to steer patients towards a particular decision by not disclosing all the options. Although this example of patient nudging happened in the community, it is also common within the hospital.

*One woman wanted me to care for her and I was busy, and I said, 'Actually that's quite a way for me to come. Try and find someone locally'. So, she did find someone locally who agreed. And then the doctors up there were very against home birth, so they were supposedly going along with the home birth plan and then at the very last minute they got on to the midwife and said, 'You know this is a very dangerous thing that you're undertaking', and not really that enthused about it and 'be it on your head if anything bad happens'. And we needed a GP and so this woman rang me and said, 'The midwife has pulled out and the doctor's saying, of course they would offer care, but the midwife has pulled out. Which was just lies and I said, 'Well, let them know, 'No, the midwife hasn't pulled out. I'm coming up'. And I went up. The doctor immediately rushed off something for the day, kind of arrived back after the birth was all over and walked in and said, 'Oh well, I'm not really needed, am I?' She had had a wonderful birth, and I said, 'No, you're not'. So, their game playing I had no time for. (Carolyn)*

Home births were somewhat accessible in areas with supportive GPs. However, not all areas in New Zealand had GPs that were willing to attend or sign off. The Domiciliary Midwifery Society, the Home Birth Association, and Save the Midwives shared information with each other about which doctors were supportive, who was not, what doctors would interfere, and where there were no GPs available.

When the small primary maternity units closed, women had only one option for childbirth - the main hospital - which participants described was highly medicalised, excluded husbands, and immediately removed babies taking them to the nursery. In some areas home birth was an option with domiciliary midwives and supportive GPs. However, the financial reimbursement did not encourage more midwives to work in the community. Domiciliary midwives considered GPs as colleagues, while GPs saw midwives as subordinates. Although the midwives 'managed' GPs' attendance, GPs benefited from the system either way. There was no incentive for them to change the status quo because they were holding the purse strings.

While some GPs were described as merely being afraid of birth, other GPs intentionally obstructed home births. The relationship between the midwife, the woman, and the GP varied in different areas of New Zealand. Some GPs attended, some did not, but they were paid a fee regardless of their attendance. Sometimes it was the midwives who decided when or when not to ring the doctor, and at other times it was the labouring mother who requested not to ring the GP. The stronger relationship was between the mother and the midwife. The domiciliary midwives' and women's relationships were founded on partnership and consent, terms to be coined later. Additionally, the midwife was an invited guest into the home of the family placing autonomy with the woman; it was not a medical institution where the practitioner's word was law and the consumer's voice was largely silenced.

#### 6.4 Relationship Between Consumers and Domiciliary Midwives

*We were trying to elevate midwives as the guardians of natural birth. (Glenys)*

Among the consumer participants it was evident that, unlike midwives who experienced shifts within the profession over time, their belief in home birth and physiological birth remained consistent. Of course, consumers recognised the shift in birthing practices with the increased dependence on technology and could understand the reasoning behind this shift. However, there seemed to be a wider distance between the midwives and consumers, where once they had been considered partners. The midwife participants, as a group, had adapted their perspectives around childbirth. Although both groups were critical of how medicalised the midwifery profession has become, the collective group of midwives seemed to have more

compassion towards the constraints their practicing colleagues were dealing with. Most of the consumers had not worked in medical facilities and were not subjected to a type of clinician drift where practitioners were 'socialised' towards adherence to medicalised practices. When the consumers shared their philosophy around birth, it was informed by their lived experiences of collating home birth statistics, working in the scientific field with large mammals and normal physiology, and having attended many home births.

Participants discussed their motivations towards fighting to change the maternity system. Glenys speaks more generally about the medical culture and how the exposure of events around the 'Unfortunate Experiment' highlighted the broader implications for women in all health services. She talks about with how those events, coupled with feminist movements, women began to develop agency around inclusion within decision-making processes.

*The Unfortunate Experiment raised a level of alertness, particularly around informed consent. The discovery of body parts of children that were not returned following the autopsy and stored in formalin jars. Placentas were being collected and used without consent for the extraction of hormones and other biochemical substances. All these situations were floating around us and there were like-minded groups getting together saying, 'this is all about women being done to and not with. We don't need this, we don't need this gatekeeping, we need to be empowered to exercise informed consent'. (Glenys)*

Brenda explains how the global feminist movement provided women with language through which they could claim agency. She talks about the relationship with feminism and how the patriarchal obstetric community used its authority to control women through minimising their choices. She explains the medical establishment's intentions to retain control over nurses, midwives, and women, by closing the primary maternity hospitals.

*The obstetric organisation at that stage was actively pursuing a policy of regionalisation. They definitely didn't want women to give birth at home; they wanted ALL women to give birth in major hospitals where obstetrics defined the protocols and dictated the scope of practice of the midwifery and nursing staff. Primary birthing hospitals, all the maternity hospitals, and just about every little town used to have one, were being actively closed down. So, there was no push within the maternity system to even consider domiciliary midwives. It had been*

*completely forgotten that this was still on the statutes in 1974, and it was the feminist movement, 'Our Bodies Ourselves' etcetera, the 'I'm not going into your hospital and have you men fiddle with us. We want to be looked after in our own homes by women', that revived the homebirth option. (Brenda)*

Brenda and Glenys describe the consumer perspective for the impetus towards change. Their sentiments express what women were fighting for by alluding to what they were fighting against. They wanted empowering birth options and control over their experiences. They wanted shared decision making and to know their practitioner; essentially, they wanted what domiciliary midwives provided.

Bronwen describes the feminist motivations from the domiciliary midwives' perspective. The collective fight was about so much more than simply the option of having a baby at home.

*In the 80s, that whole reclaiming birth was for women and midwives getting their autonomy back. It really was about encouraging women to be as big as they could be and not be subjugated by the prevailing culture, either internal culture of the whole health system or society's culture of where women stood. This seemed to be an area where women could stand up for themselves and say, 'No. I want to do this birth, this way'. And unfortunately, at that time, the only place really that you could do that, that wasn't systematised, was staying outside of a hospital... So it was 'Home birth my way', but in the end it became bigger than that and became 'Birth my way, irrespective of where I am'. What the midwives who were involved knew was that if you stayed at home, it was much easier for you to do exactly what you wanted. And it was certainly much easier for the midwives to behave the way that they did, except for this thing that overrode the legislation that the woman had to have a doctor. (Bronwen)*

Marjet highlights what was then, and still is now, a common response when telling some people when planning a home birth.

*I had a friend who had done a medical laboratory technology training with me. Her husband was a trained doctor, and they lived just up the road. I went around there to tell them that I was pregnant, and planning a home birth and Phillip said to me, 'Just because you're white-middle-class Marjet, that doesn't give you the right to be irresponsible around the birth of your baby'. ...He was a GP for a long time and I'm sure his views have changed around that. But it was like, 'How dare you say that to me?' So that was another real defining moment for me. (Marjet)*

Joy elaborates on the model of service, and identifies that Plunket had come to visit her. Plunket is a well child service that monitors a baby's development from 6-weeks to 5-years of age. In her passage, Joy outlines the importance that the continuity of practitioner was for her.

*But the continuity of care, that definitely did come through strongly, it had been something that women did care about a lot. I certainly cared about it a lot, in more than one way too... Someone from Plunket turned up on my doorstep unannounced one day and they had a student with them. They hadn't phoned ahead or anything, they just expected to come into my home, and I'm normally a pretty easy-going person, I usually would just say, 'Oh, yeah, sure'. But at the time I remember thinking, 'What? No, I don't think so'. And I said, 'No. I don't think I need Plunket services. No thanks. It's all right. I'm fine'. So, a couple of things are going on in my head. I had just had lovely continuity of care with Andrea all the way through and so I felt I didn't need that. I was fine. And Andrea looked after me, so I didn't need anybody else. The other thing that crossed my mind was if say the practice nurse from my general practice had turned up on my doorstep unannounced, I would have thought, 'Oh, how sweet of you. That's really nice of you. Gee, thanks for making the effort, come in'. So that's about what a difference it makes to have continuity of care for someone who's accessing health services. (Joy)*

The continuity of practitioner Joy experienced was not consistent across the country. It was available in the Manawatū because the local Home Birth Association was very strong. What is clear is that her practitioners had referred the services to her and Joy felt confident in her parenting, breastfeeding, and her baby's health that she declined the well-child service, and continued to see her GP for any concerns.

Brenda outlines how fractured the maternity system was for pregnant women more generally.

*In lots of areas there were very few doctors providing maternity care, so women were getting no continuity. They were going to the hospital teams, the antenatal hospital team, then labour and birth somebody else, and often a variety of people postnatally. And the same for the women who were referred to a neighbouring doctor. They may go to their doctor for their early antenatal care, a different doctor for late pregnancy and the birth, then the hospital team would provide the postnatal care. It was just ridiculous. (Brenda)*

As Brenda continues, she shares an example of a conversation with her midwife, a discussion that would not have been available to her in the mainstream medical setting. She outlines the decision-making authority that was only available to the home birth women. Brenda had previously had a caesarean section and was planning a vaginal birth after caesarean (VBAC). She explains that in a hospital setting, she would not have been allowed to attempt a vaginal birth. Brenda was well positioned to make an informed decision, having attended births in hospital in early nursing training and home births. She was also a consumer health advocate on several committees. She understood, more than the average person, the potential liability and professional retaliation that her midwife would have been subjected to if something were to go wrong. The example touches on the reciprocity of the woman-midwife relationship which was evident in the homebirth community, although not present within the mainstream medical system.

*The midwives looked after us in terms of monitoring our well-being, but we looked after them as well. We were feminists, and we were very clear that we were responsible for our choices. We said to them, 'This is my decision, document it. MY decision. You've told me what you recommend/are required to recommend... and I've chosen...'. I was one of the first women to have a home VBAC and I said to my midwife, 'You've recommended that I go to hospital and I've refused', like that. 'You need to cover yourself. You're not expected to carry this. This is my decision that you are supporting out of the kindness of your heart and at considerable professional risk if it turns out badly'.*  
(Brenda)

Brenda describes the personal ownership she had over her birth experience but also identifies how she understood there was potential for backlash towards the midwife. Both Brenda and her midwife, Joan, were aware that Brenda would not be 'allowed' to attempt a vaginal birth within the hospital setting. It was not an option in the 1980s. Brenda describes the partnership model, one of the core tenets that the New Zealand midwifery system is based upon. Partnership inclusive of true informed consent but, more than that, it is regarded as the professional friendship between the midwife and woman (Daellenbach, 1999; Guilliland & Pairman, 1995). This happens when the individuals trust each other and equally share the burden of responsibility. However, more than that, it occurs in a context of agreeing to do something in the context of what Brenda suggests would be deemed 'dangerous' or risky within the system.

Carolyn describes the strength of the relationship and the partnership, midwife-woman bond, from her practice experiences.

*So yes, you would commit to care more times than what you should do but there was an absolute sense that you were all standing together and what everyone was out for was a better birth experience for those women and for those babies and for those fathers. So, if you set everyone up on the best starting point possible, you're actually doing a great service for the social community. And when any of us got picked on, then those women were right there beside us, defending us to the n<sup>th</sup>, really. So, it was a completely different relationship that you had... they felt very privileged to have a midwife who was working for a pittance to make their dream come true. (Carolyn)*

In supporting women to birth at home in an empowering experience, Carolyn describes the action of domiciliary midwives as making “*their dream come true*”. Joan Donley’s granddaughter, Tamarin, identifies the contrast between the hospital attitude towards Joan and the relationship she had with the women.

*They would definitely make it very difficult for her whenever she had to go into hospital with a woman. That's where you would see it, you would see that vitriol come out there... It was like an invisible wall you could feel it, it would come down. But as for the women that she looked after, there was so much love for her. (Tamarin)*

The vitriol of an invisible wall towards Joan highlights the deep contrast between the homebirth community versus the medical model. In revisiting Brenda’s language, being ‘allowed’, identifies a situation of ‘us against them’, in as much as it was reclaiming of birth as Bronwen had identified. There was no space within the routine hospital processes which allowed for individualised treatment. As Tamarin continues, she foreshadows the collective politicking that took place.

*I remember being at her house when she'd have the pow-wows with the midwives and they would be brewing up some little strategy. It was very powerful. Those women were really on fire and definitely Joan was steering that ship and encouraging them all to step up and get educated and understand how it all worked. So just to even be around that, a group of empowered focused women, yeah it was quite amazing. (Tamarin)*

The home birth community became political when they learned about upcoming health reforms. Their goal was to ensure practitioner continuity, connecting it to their empowering birth experience.

*I had Murray and Andrea, so I mean, the dream team and so very, very lucky and I had fantastic continuity of care from both providers. This is definitely something that you feel like you want to safeguard and make sure that's available for your daughters in the future. So, we knew there was change afoot and we wanted to be proactive about that. We didn't know exactly what was coming and we wanted to preserve the option of homebirth in the midst of whatever the change was coming. (Joy)*

Joy mentions that she had a dream team and continuity of care from both her practitioners. She also mentions that the community needed to be active to protect the options for the type of healthcare they valued. To ensure that an empowering birth experience with midwives remained a viable option, collectively, as women and midwives, they needed to become political. The salary needed to be viable, and midwives needed to be paid at a rate that was a living wage. Andrea, Joy's midwife, explains how the home birth community devised a barter system to show appreciation and supplement the inadequate pay midwives received.

*The consumers were definitely a very supportive group and because we earned such a pitiful amount of money for the births. When you had the baby, you would give the midwife quite a substantial gift of money or often meals. But also, for the women, the home birth community; meals would arrive for a week and the roster, there'd be quite a bit of help, nappy washing, going around to help with nappies and things like that. (Andrea)*

The consumers shared how the home birth community extended past the immediate post-partum weeks. As a community, the families would socialise together, going camping or learn parenting strategies from each other. The social aspects provided strength through difficult times. They became a strong extended family, empowering each other and leaning upon one another. Together the community experienced deeply personal and raw moments of the human experience.

*One woman in our group had a little boy born at home and he had a diaphragmatic hernia. He was oxygenated at home, and they got him to hospital to find it was irreparable. This mother's journey was well supported through the process of removing the life support, making*

*her experience no less tragic, but full of acknowledgement of her grief in an environment of no rush to make decisions and take it all in. It wouldn't have mattered if she was in the hospital or not, but what I saw was a well-supported woman, because the structure of the community was already around her and that's what homebirth gave to you. Like-minded women sharing their experience and knowledge. This is the most empowering way of sharing and learning, being amongst this group of positive women. (Glenys)*

Participants discussed partnership by sharing their experiences. Their relationships included sharing information, food, and their time. Together they were protected against the larger medical 'institution' by navigating the health system, learning their rights, and educating each other. Bronwen justified working outside the statutes to support women choosing to birth at home, justifying her 'duty of care.' She shared her actions within the domiciliary midwife's society newsletter (Pelvin, 1988) and her home birth work was celebrated in the *Listener*, a nationally syndicated magazine. The home birth midwives and their wider partnered community was a close-knit group because they supported each other from outside the mainstream system.

## 6.5 Conclusion

All participants spoke of the paltry financial implications for attending home births, compared to the fees GPs were paid and the salary of obstetric nurses working in the hospital. The consumers and domiciliary midwives supported each other's needs by working towards a common goal of empowering birth experiences, outside the literal and figurative 'system'. Guilliland (1989) recognised, "the only real power base we have rests with the women we attend" (p. 14). Non-market transactions are not calculated by the gross domestic product (GDP) (Hyman, 2017), and in economic terms the homebirth community was acting in a non-monetary economy heavily reliant on bartering time, meals, and altruism. As this is not measurable, it is easily dismissed as invisible.

The communities developed a self-funded system with regional and national networks, communicated through their Home Birth Associations, and broadcast messages through Save The Midwives publications. This underground communication strategy penetrated the wider feminist networks where the HBAs were able to publish articles in magazines such as *Broadsheet*, informing the critical mass of women's health issues.

These underground strategies were bubbling beneath the surface - connecting people and sharing information and was largely unnoticed by mainstream culture.

This chapter focused on childbirth within the hospital system for hospital maternity patients, home birth women, hospital midwives, domiciliary midwives, and GPs. This chapter also outlined the complex relationships between the domiciliary midwives and GPs wherein the fee structure allowed GPs to collect payments for services that midwives performed. Sections within this chapter showed that maternity services were fragmented and difficult for patients to navigate. The research questions I set out to answer within this chapter were:

- What aspirations did these participants have for maternity care, and how did they envision their role in shaping its transformation?
- How did participants experience the maternity system prior to the enactment of the Nurses Amendment Act 1990, what challenges did they encounter?

In addressing these questions, throughout this chapter participants' stories identify the standards of practice which they came to reject. In outlining the relationships between practitioners and women, they have identified how they began to transform, for themselves, a maternity service that suited them. These participants were responsible for shifting and, ultimately, changing the standard medical procedures in New Zealand before and after the Act. Midwife participants discussed the working conditions within the hospital culture, while consumers discussed the changes to the patient experience. Participants identified their reasoning for rejecting the common practice of the day, the funding schedule for domiciliary midwives, and their relationships with GPs. Additionally, they justified their formation of activist groups and their reasoning for interrupting standard medicalised practices by taking birth outside the institution and advocating for different childbirth experiences. Participants described how, over time, they disrupted the prevailing cultural norms surrounding childbirth.

The metanarrative identified that the home birth consumer activist movement was a fight for midwifery autonomy, fair compensation for midwives, and for midwives and women together to reclaim birth as a woman-centred experience. The financial structure from the 1930s privileged doctors and devalued the work of midwives, despite their considerable time commitment to support women at home. This chapter

has presented participants' experiences of the authoritative and rigid medical model and the reasons for the collective action towards developing a collaborative and flexible home birth midwifery service for practitioners and families. Additionally, this chapter has described the historic and ongoing patriarchal structures, and the influence and impact on maternity services in New Zealand, which will continue to be highlighted throughout the findings.

The metanarratives identified in this chapter were the patriarchal structure and the impact and influence, thereof, on maternity services in New Zealand. It reflects the authoritative and controlling rigidity within childbirth practices, highlighting the disparity between the medical model of care used in hospitals and the midwifery model of care used for home births. These metanarratives link to the narrative category of this chapter as they present some of the challenges midwives faced during The Early Years.

In the next chapter, the focus is on the midwife participants, as they discuss how, through their experiences, they became domiciliary home birth midwives. Participants identify the backlash and retaliation once they were successful in increasing funding for midwives, after successfully passing the Act. The medical fraternity fought back as their financial monopoly in maternity services was threatened.

## Chapter 7 Findings: Narrative Category - Learning, Unlearning, and Relearning: A Practice Shift

*There are different sorts of change agents, aren't there? There are the ones who are right at the beginning, and they break the rocks up. They really are big rock breakers that have to be quite assertive, really clear about what's needed and you have to just keep hammering away until the rocks are broken. Then you need the people who turn the rocks into the pebbles, and then you get the maintenance people which maintain things. (Jackie)*

The narrative category—learning, unlearning, and relearning: a practice shift—outlines the midwife participants' experiences. In reading the midwives' accounts, I recognised strong narrative threads pertaining to a shift in their rote learning and menial tasks within the hospital system to beginning to question the standard treatment. The categorical content story map grid that outlines the chapter sections can be found in (Appendix E). Reflecting on their clinical assessments, they were able to pause and identify the areas of their practice that they needed to focus on to become domiciliary midwives.

Participants shared that the hospital policies promoted fear of childbirth in both practitioners and women. They began to question the standard clinical procedures, and upon reflection made changes in their own practice. Through the processes of questioning and reflection, they gained confidence in themselves and began to intentionally seek out new experiences, which were very different to the practices than they had been taught in the hospital. Through these experiences, they realised that their hospital learning did not provide them with the skills or knowledge that was required of them to work in the community. They had the technical skills for their role as obstetric nurse in the hospital; however, their reflection sparked an awakening which ultimately led to a major paradigm shift.

Participants expressed that by attending women at home they developed a sense of confidence in women and in birth while they were unlearning their indoctrination of medical policies and procedures. At the same time, it was through the supported relationships with women that they had space and capacity to confront the ingrained fears they had developed from the institutional training. As they shared their

experiences of 'relearning', they described the strength that they found in becoming part of a wider community of domiciliary midwives and home birth consumers that extended across the nation.

The metanarrative identified that within the intuitional hospital system, the patriarchal hierarchy influenced maternity services as characterised by rigid protocols, embedded surveillance, and an emphasis on individualism. These features reflect male-dominated, capitalistic, and religious ideologies that promote self-reliance. In contrast, the participants as home birth activists fought against the dominant social norms, promoting health education and births at home, an extension of a woman's domain where she was free to birth 'her way'. Through the HBAs, the community based 'matriarchal' model fostered community support, promoted empowering births, and shared responsibilities for each other after birth. It was through these networks that participants were able to disrupt the dominant medical model and implement the midwifery-led model of care, supported by Helen Clark proposing the law change.

Participants described how primary labour and birth were very different experiences depending on the location, home or hospital. Carolyn discusses that through the process of reflection she began to question standard procedures.

*I gradually started to realise that there was something about women that came in really late to have their babies, and we hadn't time to do the shaves and the enemas and all the things we had to do to them. There was something magical about those births that just wasn't there otherwise, and I began to think there's something special that happens when we don't get there and mess it up. So, I started to get really captivated by what was it that we were doing that shouldn't be done. (Carolyn)*

As a hospital midwife, Carolyn's experiences were primarily routine, medicalised labour, and she generally did not have opportunities to unlearn within that institutionalised framework. In an earlier quote (section 6.2), she mentioned that Joan Donley told her to go provide home care for a woman that chose to birth at home. These experiences put Carolyn in the position to use her clinical skills autonomously. Many hospital midwives did not experience the unlearning that began with questioning the standard practices.

The domiciliary midwives had transitioned into primary care practitioners only using the hospital when clinically required, not as routine. After all the years of advocating, activism, writing, and political work done by the domiciliary midwives, consumers, and home birth community, the Act finally passed. Hospital midwives left to become independent case loading practitioners because the role offered professional autonomy; and, it was finally lucrative. There was residual animosity from the home birth community because midwives who were new to the community had not always been collegial or professional towards the home birth community if they needed transfer to the hospital during a birth.

*Then came the exodus of midwives from the hospital and they'd bring all their women into the hospital to have their babies or work with obstetricians. (Joan)*

*We called them, 'med-wives'. (Susan)*

As the 'med-wives' had not shifted their medicalised practices, they had not unlearned the fear of birth and continued to use routine medicalisation taught within the system. They continued to medicalise pregnancy, labour, and childbirth. Participants shared their experiences of what birth 'could be' with less interference, which set them apart from the dominating culture of medical models surrounding childbirth. As they shared their experiences around their relearning, they remarked on the privilege to have had the collegiality and supportive relationships with women. These relationships allowed midwives flexibility to bend the system for the benefit of the women. Locally, midwives coined this phrase as working 'out on a limb' (Banks, 2007).

This chapter presents the narrative category 'learning, unlearning, and relearning', which contrasted with the historic cultural norm expected of women to submissively accept that 'doctor knows best'. A metanarrative of this narrative category apparent in all the participants' interviews was a dissatisfaction in how childbirth was managed within the hospital system. Participants discussed how through their collective action, they challenged the dominant medical model from outside the system.

This chapter begins with participants reflecting on their experiences and their strategies in agitating towards the law change for the Act to pass. Although midwives became autonomous practitioners overnight, these participants had already

developed professional midwifery frameworks for practice, and they discussed their years of preparation for the legislative change. The chapter concludes by exploring the transition in the relationship between the GPs and midwives. Tensions arose when financial negotiations were successful in increasing the professional status of midwives from the doctor's subordinate to a financially equal colleague. The response from the GPs was to withdraw their trusted support.

## 7.1 Experiences of Midwives Unlearning and Relearning

*I've always said, the midwifery profession has no business harbouring practitioners who are frightened of the very thing that they have to deal with, which is women giving birth. You've got to get your head around that. You've got knowledge. You've got strategies for dealing with stuff. You've got diagnostic abilities that you are supposed to use to pick up what's going on, and you will make mistakes. We all make mistakes, and you just have to suck it up. You just have to actually be a big strong person and deal with it because that's your job. And I think some midwives are unable to develop that. They just can't... to me it's a very interesting field to have been working in because it fronts you up to a whole lot of stuff but, in the end, it fronts you up to yourself. (Bronwen)*

Bronwen's quote reflects the core of professional accountability in midwifery. Her words draw attention to the incongruity of a profession centred on childbirth that harbours practitioners who are fearful of precisely that act. Embedded in her statement is a challenge to midwives to cultivate the psychological readiness and professional courage required to stand firm in the face of uncertainty, unpredictability, and the inherently unstructured nature of birth. Midwifery, she implies, is not a practice built on formulaic or protocolled reactions, but one that demands an embodied, situated knowing. A willingness to meet its complexity not with avoidance, but with informed presence. In confronting the unknown, the practitioner is also forced to confront herself; midwifery becomes a mirror as much as a vocation. What Bronwen infers is a call to transcend the 'safety' of medicalised routines and, instead, step into a space where intuitive, grounded, and relational ways of knowing are prioritised—that which some might call midwifery ways of knowing, which have long been sidelined by dominant institutional cultures.

Participants share how they were able to unlearn their deeply rooted 'entrenched' training of the hospital system through questioning their practice and moments of

realisation. Carolyn attended home births with Vera, a domiciliary midwife who was in her 80s, and was exposed to situations that were never 'allowed' on a labour ward, such as fathers and siblings being involved in childbirth.

Although Carolyn had attended many home births, the medical mindset of surrounding birth continued to dominate her decision making. However, her inquisitive nature and critical thinking prevailed as she began attending birth at home. Carolyn illustrates the skilful questioning required of a reflective practitioner.

*Then gradually you started to question things, because there was a very strict rule, if women hadn't birthed their baby in 2-hours it was like an automatic forceps delivery. And I can remember standing at home and thinking, 'Oh this is such a shame, she's making progress and we're nearly there. The 2-hours are up, we have to go into the hospital, what a shame'. And then suddenly thinking, 'Hang on a minute, who made that up?' Because it was so entrenched. 'Who made-up the two-hour rule? Some guy', and then, 'No. We're not going into hospital'. And so, you had to start learning and unlearning and learning more. Like washing the baby immediately at birth and probably did that for a little while and then started to think, 'This is a bit ridiculous'. (Carolyn)*

Carolyn outlined that what ultimately shapes a practitioner's behaviour is their experience. She expressed how through deep questioning she began to consider alternatives ways of working. By thinking through what she knew to be one set of rules and then deciding that 'no', she was going to do something different. At that moment, she questioned the original clinical practice of a set 2-hour rule and decided that it did not fit within the clinical situation presenting. Once she realised how deeply the clinical entrenchment bore into her thinking, she was able to employ new strategies with confidence to shift her practice.

When Norma came to midwifery, she was working in one of the small primary units. She recalls how the experienced midwives trained her to identify the difference between normal and abnormal labour.

*I remember working at [a primary birth unit] and talking to the midwives who worked there for a long time, and they said, 'Look it's easy, look after well women and the abnormal women will jump up and slap you in the face. They're so obviously needing help that it is time to transfer out and you get them out fast'. (Norma)*

As the midwives advised Norma, they gave her direction on how she would be able to quickly assess the difference between what is normal and someone who needs medical attention. In this way, their 'easy' approach to identify when physiological labour becomes complex, indicates confidence in both the process of natural childbirth and Norma's ability to recognise it. In a sense, the midwife was offering Norma, 'you can do this'; whereas in the hospital, the highly technical and fear-based approaches were prioritised. Many participants had not trained in the small primary birthing units prior to their closure and so their training did not instil confidence; rather, they were trained to manage labour with tasks.

Bronwen reveals a similar experience as Carolyn's '2-hour rule', and explains her clinical thinking in the situation. She then describes how the experience affected her, as she reflected on how this homebirth differed from the hospital births she had previously attended.

*She went into labour, and I was just starting to think, 'Oh, if she doesn't have this baby soon, we probably do need to go into hospital'. Then about 5-minutes after that she wanted to push her baby out and she had a gorgeous little baby. It was very rural. It was totally quiet. You had the Wanganui River down below and somebody, somewhere was sitting on a hillside playing a flute, like it was really quite idyllic.*  
(Bronwen)

Bronwen does not go into details about what happened at the birth or the clinical events which took place. She shares her thinking, and that she simply waited for the labour to unfold, like Carolyn. However, the focus of her recollection is how the setting of the birth affected her. She mentions the experience being 'idyllic', quiet, near the Wanganui River. As the third longest river in New Zealand, it has the same legal status as a person. For Bronwen, the depiction of this birth experience could not farther from a medically managed hospital birth. The scene is not as much about the birth as how the experience shifted her practice. This birth was a very different experience to those in a hospital setting. The scenery, location, and calmness of the event showed Bronwen what supporting normal birth at home 'could be'.

Susan describes when she first heard about 'home' 'birth'. She outlines her introduction to this new combination of words, candidly sharing her initial thoughts and feelings. As she continues, she discusses how different the management of birth

was, simply because of who was there and how it was managed, and the striking realisation that women were not screaming, they were not afraid. She shares that her clinical experience within the hospital did not prepare her to clinically assess a labouring woman having a homebirth; the whole 'process' was different.

*My highlight was going out with Joan Donley. We had a midwifery meeting, this would have been '76, I suppose, they talked about home birth, and I went, 'Home. Birth.?' I had never heard those two words put together, never in my life so I was like, [whispers] 'that's weird'. I wrote to [Joan] and said, 'could I come up and work with you?' and she said, 'yeah, sure. Come and work with me'. I went around with her. We turned up at the door, and I would think, 'oh, they're obviously not in labour'. [But she was] 5cm [dilated] because she always did a VE [vaginal examination] on arrival. They were different, like they were completely different. Their partners were supporting them, their friends were bringing food in. Babies didn't have dextrose to start off with, they only had breast milk... The whole process, I had been taught, was very medicalised, so for me it was absolutely stunning. To have births where the women weren't curled up in a ball or in angst or climbing on the bed screaming. It was so different, it was a different process, and I had an epiphany. I thought, 'Oh, this is amazing. This is all I want to do'. I was completely committed... people having home births were less scared. Then I transitioned to doing home births and was like, 'Ah, I'm home now'. (Susan)*

Susan describes contrasting procedures; the hospital which focuses on practitioners doing things and at home where the focus is on the woman. Support to the woman came from partners and friends, which seemed very strange to her. Then the baby breastfed rather than practitioners stepping in and giving dextrose. Susan's whole perspective changed about birth. Home birth, being a completely different process, changed Susan. She went from not enjoying being a hospital midwife to having an 'epiphany' about home births, they were 'amazing', 'all' she wanted to do. Susan found herself as a midwife in the fullest sense.

Like Susan, Joan's midwifery experience was entrenched in the medical model. She describes being surprised that her first home birth did not end in a death of mother or child. The fear-based hospital methods were essential in reinforcing the dominance of the medical model with a threat that any diversion, someone will die. However, as Joan recounts her experience, she shares how she transitioned into being a home birth midwife.

*It was amazing, the mother didn't die, the baby didn't die, and doing that for me was really brave and an eye opener. Then of course home birth was the only way to work for me. It was a different process; this was not the same thing that women do in hospital. I had to relearn... eventually I became a home birth midwife and that's a hell of a shift in terms of understanding what birth is about. (Joan)*

Joan mentions both her bravery and the need to relearn. Her previous hospital experience did not equip her to attend to women; rather, she had been taught to deliver medical treatments to women in labour. The relearning was to develop the skills required of a home birth midwife. Additionally, Joan shares how within the paradigm shift of her thinking she 'became' a home birth midwife. Her new perspective, that women and babies do not die because they do not undergo strict medical treatments, allowed her to first shift her mindset and then her practice.

Christine also shares her experience where the rhetoric of death if procedures were not carried out as commanded dominated. She recounts how a minor change in routine practice provided her the opportunity to reflect on standard medical practices.

*I remember when we stopped doing active management. The first time I did physiological management I was like, 'She's going to die. It can't be done'. And then of course you do it and in fact everything is fine and then you think, 'Oh my god. Why were we doing active management on normal women all these years?' (Christine)*

What Christine is describing here is the placenta delivery. To provide a brief context, typically after a baby is born, the uterus continues to contract to dislodge the placenta and suppress excess bleeding. Active management is when a practitioner administers artificial oxytocin via injection, or into the intravenous solution, to expedite placental delivery and discourage haemorrhage. Active management is often practiced when synthetic oxytocin has been utilised in labour and, therefore, should continue until after the delivery of the placenta. Christine is talking about the placenta naturally separating from the uterine wall and being expelled without the use of synthetic oxytocin.

Susan identified that she did not recognise the normal progression of labour; within the hospital structure, the process was so different. Joan and Christine identify fear of a death if specific procedures were not followed. Whereas Norma, who trained in a

small primary unit, could recognise the difference between normal labour progression and when labour became complicated. *'Look it's easy'* was her lesson, promoting confidence rather than fear.

Christine reflects that a minor evidence-based change in the standard hospital procedure prompted fear because of her training - what, how, and where she had been taught. Her fear contrasts with Norma's confidence, who had been taught the clinical skill of triage, assessment, and a strong foundation in primary birth.

Bronwen describes what is required to change an individual's routine practice. Having had the experiences of how birth could be different, and having been a domiciliary midwife in the community for 17-years before taking on other roles, she had been through the process of reflecting and shifting and redeveloping herself and her practice. Therefore, by her own reasoning, it could be presumed that practitioners do not employ informed consenting processes when they believe they are not performing a treatment that might be detrimental to a hospital patient. Although that may seem noble, as Christine indicates, that practice was unnecessary for so long.

*To actually change your practice requires you to do something different. So, if you've developed a particular way of practicing but you need to now change it, that requires a lot of effort, and it requires you stepping back. (Bronwen)*

These participants outlined in their narratives how their experiences allowed them to question their practice. They reflected and changed their management of birth. They sought out other domiciliary midwives as practice advisors and developed strong relationships with the home birth families.

The midwives in this section identified reflection as a mechanism to assist them in questioning their actions and changing their practice. As a result, they were open to working alongside the women and attending to her needs. Carolyn described being captivated by the magical births when home birth was supported. The midwives outlined how attending births outside of an institution provided the opportunities to experience what they described as 'idyllic' and allowed for an 'epiphany'. They demonstrated courage and bravery when frightened but stayed curious and aligned themselves with supportive networks to develop different knowledge and share in a

better experience. They observed the birth process unfold rather than stepping in because they felt insecure. They stayed engaged when what they were exposed to was 'weird'; thereby allowing them all to transition into domiciliary midwives and benefiting themselves as well as the women.

## 7.2 Agitating for Change: The Collective Organising

This section considers the actions of consumers and domiciliary midwives to 'agitate' as the HBA began to organise. The participants discuss holding conferences and community events. Midwives were still governed under the Nurses Association, and so there was a collective decision that one of the first steps towards autonomy was to separate from nursing. They would go on to develop the College and their hard work in progressing towards the Act came to fruition when it was unanimously passed in Parliament.

*As a founding member of the College, I am very proud of that. Woman/consumers became involved and that really got it there, it was very exciting. I was a new midwife, watching all these people lead this ahead of me and it was a very exciting time to be a midwife. It felt really united; we were united with women. Women were on board. (Christine)*

Norma had worked in the UK and shared a deep respect she felt from people because she was a midwife. After having worked in New Zealand, she was surprised at the comparative kindness with which she was met.

*In the UK, the midwife could get into houses that no one else could get into because people trusted them and the community model over there was strong. We could knock on these East end Glasgow doors, and they'd say, 'It's the midwife. Let her in', and the bus drivers would stop for you, and I was just like, 'Whoa, what is this?' Just loved by the community. (Norma)*

However, when she returned home, she observed the term midwife was not familiar vernacular. Bringing the confidence she felt from the UK, she and other midwives facilitated consciousness raising in their local area.

*A group of us would go out to the old city mall on Friday night and go, 'Do you know what the word midwife means?' And that was all about the word 'midwife'. No one knew what it was, it was a word that was almost gone from the language here, that was 1984-85. (Norma)*

Together, consumers and midwives promoted natural childbirth. The consumers developed Save The Midwives, using *Broadsheet* to reach a wider audience, and posted home birth announcements in the local papers. The consumers organised the HBA conferences which provided opportunities to connect and strategize. Bronwen talks about what it was like, the mood in the room, and the momentum towards shared goals.

*We just started to agitate, and we worked in all our different ways to do that. We got in touch with politicians and stirred up a foment in our areas to get midwives on-side with it. There was a backlash of the old guard, and that's still in situ. Then we had a conference and Karen stood up and suggested forming the New Zealand College of Midwives and I remember standing up and saying, 'Here's my subscription'. You know, like 'I'm paying today'. And once the College got going, it was a political machine. Its whole purpose was to change the legislation, and we were just very, very fortunate that the person at the time who was in Joan Donley's electorate was Helen Clark, who then became the Minister of Health. (Bronwen)*

Midwives, as a subset of New Zealand Nurses Association (NZNO) observed that any request or concern was either outright refused or disregarded. Nurses made up most of the large organisation, and midwives had very little power within this group. As midwifery membership became stronger in numbers, and in messaging, they gained traction towards separating and forming the College.

*We made the really big decision to exit NZNO. I remember sitting in the old Christchurch Women's, 'Are we all agreed that we will close down the Midwives Section of NZNO here in Canterbury? All those in favour?' And then the whole room did this [raises arm]. So that's done, and then, 'All those in favour of starting the New Zealand College of Midwives, Canterbury West Coast region, all those in favour'. 'Yes'. We did it at the same meeting. Then we all paid \$50 to be founding members of the New Zealand College Midwives. (Norma)*

Once the College got moving, the midwifery standards review was brought under their umbrella. Professional frameworks, a constitution, and formalised communication through a professional journal were developed.

Bronwen described the College as a 'political machine'; midwives and women required reinforcements in their 'agitate' for parliamentary changes. During the time that the College was formed, between May 1989 and August 1990 there were a series of Select

Committee hearings in Parliament. Helen Clark, and her team, drafted the legislation through a standard consultation process during which individuals and organisations would submit written feedback on the drafted bill and request an opportunity to present their views. There were 99 written submissions, all in support of the Nurses Amendment Act (Keall, 1989). Those granted a hearing were allocated a time to provide additional information beyond their written submission or to respond to questions the committee may pose. Following, the feedback was analysed and the proposal revised as legislation. Teenha Handiside, one of Helen Clark's aides involved in this process, was in the room and discusses the tenor on the day.

*I had never been to a select committee before, and I had to sit there with a scribe and a lawyer. I had to answer questions from the MPs, but because the select committee was so huge, they had it in the legislative chamber, which is where they swear in the Prime Minister in Parliament. It's a huge and very old-fashioned room and it was full of what I used to call, 'The men in their Italian suits and leather shoes'. There were obstetricians and there were the women with their pushchairs and breastfeeding babies. It was just a real cross section, of women and babies being present; that was very important as well. There were TV cameras everywhere. It was kind of like a war. It was always a bit like that with men and women, 'us and them', I suppose it was a bit like a fight to keep going. The obstetricians were all in the front row. They were all heard first because of course, they're all very busy people. But the women, breastfeeding mostly with other kids at home, she was heard last. That's just the way it was. The hierarchy in the health service and society. So, yeah, interesting. (Teenha)*

This section outlines the activities participants identified that created the social changes which led to the passing of the Act. They had a united message which they advertised widely, using all available networks.

### 7.3 Dismantling the System: The Rock Breakers

*We were very close to losing midwifery altogether, very, very close. And at the last minute basically woman and midwives got together and got the law changed which was a miracle, really. All the lovely strands came together to make it happen which was great and practicing right after the law change was just miraculous, I just adored it. (Joan)*

When the Nurses Amendment Act passed unanimously through Parliament, participants recounted where they were in that exact moment. Decades of tireless

work towards this moment and they had finally achieved. They discussed this emotive moment; members of Parliament supporting midwifery autonomy. One participant shared how they listened over the radio, another was listening alongside her midwifery class, and another was physically in the room at Parliament in Wellington.

*We were at the Conference, and it came through that it had passed in Parliament, and I remember us whooping and jumping up and down, carry on. We made Helen Clark an honorary midwife. Well, she midwife-d it through the whole parliamentary process and it was fantastic, and my memory is that it was unanimous. There wasn't anybody who [voted against it], because why would you? So, nobody did. I just think there was such a lot of work done by the midwives in the constituencies. It was unanimous across parties, which is pretty amazing, really. And then of course we had to fight the funding issue.*  
(Bronwen)

Bronwen, at conference with colleagues and women, upon hearing the legislation supported unanimously reasons that everyone worked so hard, so it was bound to happen. She also indicates there was no reason to vote against it, as midwives had already been managing labour from standing orders. Although a hugely successful achievement, Bronwen includes some foreshadowing as she indicates that although this battle was won, they had yet to fight the economic war around pay equity.

Suzanne describes listening to the Act being discussed in Parliament over the radio. A student at that time, she describes the moment as 'really heady' and how this moment later affected her understanding of politics and larger social changes.

*We sat in class and listened to Parliament pass legislation on the radio. I remember there being this incredible sense of potential and excitement, it was really heady, it was a really amazing time. Being a student in that year it was like you were on the precipice of something really momentous, but not really being sure what that was about and not really understanding what had led up to it. After I graduated what occurred to me was that partnering with community groups led to that political change and it was quite politicising for me. [It] made me think about how change happens in society and that sparked an interest about how movements for change work.*  
(Suzanne)

Susan attended the changes in legislation in person with her daughter. She expected that more women would want home births, now that it was acceptable.

*The changes in legislation were extraordinary. I went and watched it go through Parliament, and I was so thrilled, and I thought, 'what's going to happen now is, in the next 10 years 80% of women are going to home birth'. I was a home birth midwife at the time and very excited because it meant if I had to transfer someone, I could stay with them and that seemed extraordinary to me. So as soon as the legislation changed, I was accepting women for hospital births as well. I did a mixed practice because of course a lot of women weren't ready to have home births straight away. (Susan)*

Susan shares one of the barriers that domiciliary midwives faced in transferring a home birth to the hospital when a woman was in labour. The midwife could then not continue to attend to the woman and was required to hand over the patient to the hospital team. Women who had planned a home birth were given information about potential transfers, and participants described these as difficult for both women and midwives. Mostly domiciliary midwives were met with animosity, rather than collegiality, and patients were also treated poorly. Home birth women were subjected to having to listen to their trusted midwife being spoken about negatively because they were seen to be defying the status quo. Women who merely questioned treatments were considered as challenging the system and often labelled, 'bad patients', or 'feminists'. For some, such labels were meant as an insult. Karen recalls, "*I was accused of being a man-hater, a 'hairy legged lesbian'. I don't know what's wrong with that, personally*".

Susan's husband is a doctor. She discusses that on the day the Act passed in Parliament, she went to his office. He was completely unaware of any impending changes to maternity services.

*I remember walking up to John's office and saying, 'We've just passed a Bill allowing midwives to practice autonomously'. And he said, 'That can't be right'. I didn't tell him what was going on because I didn't want medicine to get a word of it!! [laughs] (Susan)*

Laughing, Susan mentions that she did not want to alert 'medicine' to this major event. She is alluding to, but not explicitly outlining, the depth of doctors' antagonism towards midwives. Participants discussed that there was no objection in Parliament voting for the Act because the most opposed group, doctors, had not been aware of what midwives and women were working towards.

*There was no real impediment to everything. The doctors were remarkably asleep, they were just asleep, they had no idea it was going on... They were completely unaware. We know that, because if they had known, they would have risen up against it. (Bronwen)*

The medical community was completely unaware of what was happening around them; their maternity patients, their wives, their communities were fighting to change the health system for years, using communication outlets such as magazines and newspapers to engage and educate and inform the public (Gendall, 2001). However, the medical community were 'remarkably asleep'. This statement links to a larger metanarrative of the privileges afforded to the male dominated medical community.

Bronwen's statement explains that doctors would have made attempts to restrict or derail the Act. The immediate changes meant that midwives could attend births without a GP sign off, in hospital or at home. They could order scans and medications, and claim for the maternity fees for antenatal, labour, and postnatal appointments.

Prior to the Act, participants described the midwife-GP relationship as supportive or neutral. Doctors supported home birth while they collected payment; and in hospital, obstetric nurses managed labour anyway. However, once Parliament supported the Act, it was perceived by doctors as challenging their financial interests.

Participants discuss how, through the home births, midwives unlearned and relearned to support physiological birth. Together, midwives and women set about to educate the wider community around the new maternity model. It was their intention to dismantle the medical model for all of society for women that did not require hospital births. In reality, those practicing under the dominant medical model fought back.

Bronwen states that had doctors known about the Act, they would have risen up to fight it. Indeed, this is exactly what happened after the Act was passed. Doctors began to fight against the payment schedule, and they are still fighting. Doctors argued 'safety' as their reason for not supporting physiological birth, although they prioritised neonatal safety, not safety of the mothers. They argued that the hospital was safer for babies to be born in, although for primary birth the evidence suggests otherwise (Farry, McAra-Couper, Wheldon, & Clemons, 2019; Guilliland, 2001). The medical fraternity have continued to fight against the financial increases of midwives accepting

maternity payments. The work that midwives performed did not change after the Act, although their responsibility and access to financial stability had. They were no longer in a subservient role to doctors but doctors had a monopoly in the maternity funding. In response, doctors argued about concerns for patient safety (Gendall, 2001) rather than their underlying concerns—the financial loss to their livelihood (Banks, 2007). The participants disclose how doctors attempted to retain power and control of women (including midwives) through financial means.

#### 7.4 The Dam Breaks: A Community Flooded by Midwives

*As women within a patriarchal social structure, we are all victims of conditioning, but in relatively recent times childbirth seems to have been particularly targeted for control by men. It is one of many aspects of women's lives that we are struggling to regain control over. (Judi Strid, 1991, p. 5)*

Before the Act was written into law, midwives and consumers were not resting on their laurels. The sudden allure of midwifery autonomy, coupled with the financial incentive, saw a sudden influx of midwives leaving the hospital for individual practice. In 1990, only 12 domiciliary midwives were registered; by 1991, the number of community midwives had risen to 50. As Susan, Joan, and Brenda expressed, these ‘med-wives’ continued the medical model because they had not reflected on or shifted their practice towards a partnership approach by unlearning an old way of practice and relearning a new way to practice. Further, they did not experience the trust in labour, and, therefore, did not distance themselves from hospital protocols. Without primary maternity units, birth at hospital or home were the only two planned options.

The College, determined to unite practitioners, continued the strategies that helped achieve the Act through education, promotion of primary services, and focus on professional collegiality.

It may be that some of our vision will strike a chord with you and help you understand that midwifery’s determination to have control over its existence is totally to do with ensuring the continued existence of a woman centered, family-focused primary health maternity service in this country. Everything we are doing as a profession contributes to this vision. We want every pregnant woman to think ‘midwife’ when she discovers she is pregnant. We want every

woman to approach childbirth and motherhood with confidence and joy. We want families to understand that birth is a normal, healthy life event which occurs within the community and over which the woman and her family have control. We want obstetric care to be easily available for those who need it but not applied to those who don't'. (Pairman, 1998a, p. 5)

The 1990s saw midwives working in the community, while home birth families and consumers continued working towards woman-centred approaches and continuity of practitioner. Consumers argued for fewer medical interventions in labour, husbands to be present, and better pay for the midwives attending them. In Helen Clark's address (Appendix G) regarding the Nurses Amendment Act, these issues were specifically outlined. Having a baby is not an illness and the increase of medicalisation was identified as eroding the midwife's role.

Susan indicates, many women were not "*ready to have home births*" but because continuity of practitioner was achieved, most women were satisfied. The College continued to promote the professional friendship arguing that partnership-model is what separated midwives from the enduring dominant medical model (Pairman, 1998b). As women developed the professional friendship with their midwife, they became confident that their decisions would be honoured.

*When the Nurses Act changed, people kind of relaxed more, especially the home birthers because now we could get a home birth midwife and didn't need a GP to say so. And we don't have to get anybody else to authorise who we get to look after us in our birthing process, but has there been a real shift in the intention of that independence? And that's why they call it independent midwifery. (Glenys)*

Glenys alludes to the intention of independent practice which, over time, has been interpreted in different ways. The midwives who fought for the change, specifically in support of natural childbirth, "*elevate midwives as the guardians of natural birth*" (Glenys). However, these midwives were a minority within the mainstream midwife population.

Bronwen captures the differing physiological underpinnings of the domiciliary midwives and med-wives.

*It's like why are people with no symptoms of anything wrong whatsoever going anywhere near this place called the hospital? But when you look at it, it's like, well we had a whole bunch of midwives spent their whole lives working in hospitals coming out into the community. Where were they going to birth the women? In the hospital where they are comfortable. They knew people, they knew where everything was, that was their environment and so they brought the women into their environment. They weren't confident in being in home births and so the home birth rate didn't go up, and it should have, it should have gone up hugely, but it didn't. (Bronwen)*

Besides the steady home birth rate, as Bronwen indicates, midwives continued the medical approach. For example, a group of hospital midwives were successful in thwarting active management protocol introduced by obstetricians; however, when asked about consumer input the hospital midwives obtained, the women were told “the matter had nothing to do with them” (Strid, 1994, p. 12). In effect, a similar perception held by the institution investigated during the Cartwright Inquiry was reiterated.

Brenda discusses the complexity around how passing the Act increased the number of midwives working within the community.

*We knew that if we got the Nurse's Amendment Act over the line that, the midwives who 5-years before had slandered us as 'irresponsible' and 'selfish women' to have our babies at home, would come out of the hospital in droves to provide continuity of care. But would take women back into the hospital for birth, and that women would choose that. We expected that once women could access continuity of midwifery care for hospital birth that is what the majority would choose. We were disappointed that the home birth rate didn't increase but not really surprised. (Brenda)*

The participants identified the impact the Act had for pregnant women. Notably, the word midwife was commonly used and, because midwives offered continuity of care, they were revered and novel.

*The relationships with families, being in people's homes, the good pay within just a few years. The first question a woman would ask another woman who got pregnant was, 'Who's your midwife?' It was just adorable. It was a magical change; women flocked to midwives. (Joan)*

Christine describes the uptake in services meant that midwives were so popular, they needed to create networks with each other.

*All these women wanted what we called 'midwife-only care', and it grew so quickly that I had to get other people working with me and we started a midwifery group. (Christine)*

Sian describes the shift from domiciliary midwife to autonomous practitioner.

*The early days of being midwives, being mothers with kids, it was a great time of life. I think we were really lucky to work then, really lucky. It was incredibly exciting to be able to practice autonomously. And to be paid, we just had this phenomenal increase in salaries which makes a huge difference to your life. (Sian)*

However, the practice values implicit within the home birth community were slowly becoming diluted as more med-wives came into the community. Midwives provided the continuity, which many women hugely appreciated. However, the midwife-hospital practitioner did not offer the same level or type of informed consent or relationship reciprocity as the domiciliary midwives did. As Bronwen expressed, the 'med-wives' had not changed their practice because they had not had the experience or the time required to step back that a practice shift necessitates. Luckily, the College, still in its infancy, had strong members peppered around the country to draw on for support.

## 7.5 Midwives Versus Med-wives: 'A Midwife is a Midwife, is a Midwife'

*Women are vulnerable in childbirth, people are vulnerable in death, people are vulnerable in illness. It's an area where people are very vulnerable. I'm not sure we take into account that vulnerability in medicine. (Glenys)*

Just after the Act, there were tensions between home birth and hospital-based midwives. The College, to unite the profession, focused on developing the frameworks to provide education for those medically trained who had not been exposed to childbirth as an empowering experience for families and midwives. This section presents participants' perspectives of the home birth midwives and consumers during that time. Carolyn identifies the hospital midwives' position of the individuals involved in home birth.

*They saw us as being quite dangerous. It was a judgmental thing, I think because we were defying the rules and I mean I understood that because I had transitioned from their way of thinking to thinking, 'That would be the last place I would want to go if I was giving birth myself', and then really gaining faith in the birth process. So, I had some empathy with how they felt because I felt like that once myself and they hadn't experienced and seen what I'd experienced and seen. But also, there can be a real bitchy element with midwives and there was that bitchy element that you were doing something different, and you were a 'dangerous midwife'. You got treated pretty poorly if you had to transfer in. You could not continue care, so you had to hand over these women that had utter faith in you and had come so far with you, had to hand them over at the doorway and it was really hard walking out and more or less abandoning them to what happened next. (Carolyn)*

This experience identifies that some of the home birth midwives were empathetic to the hospital midwives' position. Carolyn expresses both understanding and frustration. She acknowledges that these midwives viewed them as dangerous because they 'defied' what was expected of them. Beyond this view, Carolyn identifies a sense of empathy with their position but recognises a twinge of their judgement and being forced to abandon their women who they had developed strong bonds with through their pregnancies.

Carolyn further shares an example of what she called the '*bitchy element*'.

*I remember walking in with one woman who was so distressed at having to be hospitalised, from the entrance door to her birthing room, because she was so upset. And then I was called in to the Medical Superintendent because I'd interfered, because I'd stepped over the hospital doorstep. (Carolyn)*

Rather than prioritising the woman's distress, and ensuring a smooth transfer, the hospital staff chose punitive measures against Carolyn for accompanying her woman. The report to the Medical Superintendent appears punitive rather than medically justified, reinforcing a rigid, territorial mindset, prioritising institutional boundaries over collegial relationships or compassionate, woman-centred care.

The domiciliary midwives were not permitted to step across the hospital threshold, as boundaries of primary patient and secondary care were evident. However, after the Act, the hospital institution continued to ignore the primary and secondary care lines

at their discretion. The Ministry and hospitals continued to support obstetricians to book primary patients which should have remained under primary practitioners.

Some midwives were able to obtain hospital privileges immediately after the Act passed. Despite being able to use the institution as an independent practitioner, Susan experienced animosity when attending a planned hospital birth.

*The treatment in hospitals by staff was past bad, particularly after the change. You could be a home birth midwife before that and you were just a bit of an idiot who brought someone in who was going to be looked after by the staff. So probably 18-months later, I had a shoulder dystocia in hospital, the baby's shoulder was stuck and I rang the bell. Two midwives came to the door, and I said, 'I need an obstetrician'. And one of them went off to get the obstetrician and then came back and they both smiled at the door while I struggled with this shoulder dystocia. I sort of couldn't believe it really. I thought, 'Surely they're not going to let someone be hurt for this'. There was a level of derision about the whole thing. (Susan)*

Dystocia is when a baby's head has emerged and their shoulder becomes stuck in the birth canal. In the most trivial of situations, this merely terrifies the practitioner; at the extreme end, it can lead to brain damage or death due to a lack of oxygen. While a dystocia can happen in any location, home, or hospital, the question is, why did these midwives not step in and assist her? What Susan describes, the midwives smiling in observation rather than assisting in an emergency, contradicts the standard of practice within any setting. As Susan identified the contempt she experienced in the hospital midwives' behaviour, it seems there was an expectation that midwives would prioritise patients' needs as opposed to exhibiting hostility towards another practitioner.

Sian teases out some of the sentiments expressed by Susan above. The callousness and tensions that domiciliary midwives were exposed to by hospital midwives, led to an unpleasantness by the domiciliary midwives towards the hospital midwives when they began to practice in the community.

*I think the tensions between us as individuals. We went to hospitals with midwives giving you a hard time and because of that... Then it became quite lucrative to be an independent midwife. Those midwives who had been unhelpful, unpleasant, unfriendly all of a sudden now they were in independent practice. So I think there was a bit of, I don't know the right word for it, but I don't know that we were particularly welcoming of them and certainly in Auckland there*

*were diverse groups of midwives, some who worked very closely with obstetricians and we struggled to get those close relationships with obstetricians in the early days. (Sian)*

Sian identifies that med-wives aligned themselves with the medical community rather than with the women, as the domiciliary midwives had done. The home birth midwives practiced a different women-centred model; whereas the med-wives continued the medical model and protocols. Many women not knowing the difference were grateful for practitioner continuity. Domiciliary midwives, along with the consumers, lobbied for less intervention, informed consent, and more choice. Immediately after the Act, many obstetricians refused to work with independent midwives meaning that many women were refused specialist treatment when they required it (Strid, 1994). The domiciliary midwives who had spent years fighting for autonomy and better pay were treated poorly by the med-wives who now benefited from the better pay while maintaining a subservient role by working for obstetricians.

Karen describes that when the Act was passed there was an explicit intention that midwives would provide services for primary care and the hospital would retain the women who required medical treatment.

*The hospitals never took midwifery continuity of care on because their view was that the community midwives would be their Lead Maternity Carer [LMC]. However, we had hoped that the women that required obstetric care, the hospital midwives would be the LMCs in the hospital. These midwives would be based in the hospital and employed. Women with complex pregnancies needed a lot more referral, a lot more intervention and so every woman in New Zealand would then have an LMC. Well, no hospital did it, even though it would have cut their cost, and would have been so much better for women and their babies but that's not something that anybody's ever picked up. (Karen)*

Karen continues to unpack the problem which arises from the hospital's refusal to support the primary model.

*The teams ended up all competing for the normal woman in the community so that divided the LMC midwives and the [hospital] midwives against each other. It was never envisaged that the employed midwives would look after the normal births; that was never part of the model. The employed midwives were expected to provide their specialty and their expertise in complex care and those*

*women needed an LMC and a team support because these women's experience of maternity often required more care than normal. But what happened is those women just got left to the rostered shift system and no LMC and consequently all the employed midwife teams looking after normal women and competing with LMCs in the community. (Karen)*

As Carolyn describes, the Act allowed for continuity of practitioner, for which many people considered midwifery care. The hospital system really 'opened up' for midwives to bring in primary births. Midwives could gain access agreements; seemingly the fight was won for both women as well as for midwives.

*I think that you still had people that also realised that being at home in your own environment was a huge advantage to going into the institution, but the home birth demand lessened, and women had more control over what happened with their birth. I mean they always had a voice, but they weren't able to use their voice and to start to say, 'I want this' and 'I don't want that', 'This is how I want it to be' and 'I don't agree with this' or whatever. So the home birth demand dropped. But there also were more midwives who came out and were offering home births too which was a good thing, so home birth was still there. (Carolyn)*

In addition to making home birth more accessible, the Act allowed more options for midwives—they could work in the community, they worked with the College, they helped develop the direct entry midwifery curriculum, and apprenticed students to train the workforce. They went to work in hospitals to develop the institutional structures to unify the profession to become more collegial.

*It's quite a small workforce. So, yes, everybody knows everybody. And everybody has opinions about everybody. And, you just have to make that work within a small place and people do wear more than one hat. (Bronwen)*

This section has presented the tensions expressed by participants resulting from the law changing. It was a wonderful moment but it was almost as if society as a whole had not caught up with the evolution at pace with participants; despite how long these participants had worked towards personal and professional learning and change.

Despite participants' best efforts to educate, society had not unlearned and relearned at pace with them. Hospital midwives had differing practice philosophies, doctors fought back against the monopoly, many women did not (and still do not) recognise

birth at home means more control and less intervention. In the absence of primary maternity units, only home or hospital births were available. Hospital midwives were only exposed to highly medicalised births and aligned themselves with the medical model. The participants did not discuss feeling resentful that it was their work which provided med-wives this new lucrative role to come out and work very closely with obstetricians. This section also identified the hospital institution's failure to maintain their function around tertiary service delivery. As the maternity services funder, the MoH could have provided a distinction for appropriate service delivery.

## 7.6 The Invisible Work of Midwives

*In the end it's all down to the relationships, whether it works really well or not. The midwife with her colleagues, the women... whether that's in someone's home, she has to relate to the rest of the family and the wider whānau. Or if she's going into a hospital... it's the same and one is just a more professional level than the other. But part of a midwife's professionalism is the quality of her relationships, because it's all based on that, in the end. (Bronwen)*

Midwives who work in the community hold a heavier responsibility for the woman, something else they began to learn. Bronwen's quote consolidates how working in the community differed from working within the hospital as a midwife. The community midwifery role required a different set of relational skills to navigate the relationships with family and other practitioners, which was part of their learning.

This section describes how these midwives rose to the challenges that working in the community presented to them. Norma's discussion of her experienced in the UK where midwives could access the families that no other service could, is reflected in participants' recollections of navigating the partnership relationship. This section outlines when midwives provided services for non-residents and the additional work required. Being community based, midwives were able to access services for individuals who otherwise would not have had treatments; only because of the midwives' professional networks and relationships with colleagues.

For domiciliary midwives, working as a midwife in the community meant creating trusted relationships with women which extended to their wider family. Sian provides an example of situations midwives were confronted with when working in the

community. She mentions the term 'overstayer' which simply means a non-resident with no access to funded or socialised New Zealand health services. Although what she describes are extreme cases, situations like these are common.

*So, I'm looking after a woman who is an overstayer and I've looked after lots of people in her family. There's a child on the sofa and the smell is unbelievable and I say, 'What's up with your boy?' And she said, 'He's got a problem with his leg'. This child literally had a hole in his leg and it was a complete osteomyelitis, it was gangrenous. I'm thinking, 'This kid is going to have his leg amputated'. And I said, 'Have you taken him to the hospital?' And she said, no, she couldn't afford it. And so, I phoned Kidzfirst and they said, '\$600 a day'. At that time, they were chasing overstayers. I phoned up Starship, same thing and I said, 'I'm really concerned'. And they said, 'Well, you need to call an ambulance'. And I said, 'I'm also concerned about this family'. So, I phoned Simon Rowley [a local paediatrician], and I said, 'Do you want to put your money where your mouth is?' And he said, 'What do you mean?' I said, 'There's a kid here who's got osteomyelitis, and the mother is an overstayer. He has got to be seen and they're too frightened to go to the hospital, the kid needs to be seen by a doctor'. He said, 'Okay, I'll come'. And he saw him, and he put up a line and gave IV antibiotics and talked to her and said, 'You will not be sent a bill. We will get your child into hospital'. And he got the boy into hospital. (Sian)*

Sian outlines another complex situation where she offered services to woman without collecting payment.

*I had another woman in Onehunga, and someone in the family had gone to the MPs office and they gave her my number. I turned up and she was basically going from house to house to house, and she had been on an outer island in Samoa and an enthusiastic medical student was doing their fifth year as their elective and he picked up that her older child had a heart defect. And he gamely sent the child off to New Zealand; the child was operated on at Greenlane and died. They were all overstayers and they received a \$60,000 bill for the heart surgery. And she was pregnant, so she kept moving from place to place and the debt collectors would go in and take a TV, terrible stuff. I said to her, 'I'm not going to charge you any money, you're perfectly safe'. So, I saw her, I had no idea how pregnant she was, no bloods, nothing. Then that night someone called me and said would I go. I arrived at the house, I didn't even bring in my gear, you know, just like to say hello and she said, 'I push now?' And the next day she was somewhere else, somewhere else just to keep moving away from this debt. (Sian)*

These examples do not reflect the general community that midwives looked after; however, they do illustrate that midwives often practice out of their scope, at their own professional risk, to ensure that families are receiving services while midwives are not reimbursed for their time. While practitioners, at that time, could not claim the maternity payment for a non-resident, part of their learning was in managing the responsibility for the women in the community; something they were not exposed to in the hospital setting.

Joan and Christine also provided midwifery services to non-residents. They acknowledged often working without pay; however, they reasoned that after the Act their pay increase was substantial enough for them to justify providing care for women who needed it. The women could not afford to pay the hospital, and midwives knew they would be charged.

*We used to have home births on these women who didn't always meet the criteria, otherwise they'd be charged if they went to hospital. And our Caesar rate, we would have like two a year. It was so rare to have a caesarean, it was just really rare. We just didn't have them, and we did the pro-bono thing, for the people who were not residents, we'd all take them on and not charge them. We just did it, we just believed that they needed care. (Christine)*

This section highlights that while the salaries were lucrative, midwives continued to prioritise women rather than remuneration. They used their professional partnership model to support women by remaining accessible and providing safe services speaking to their integrity and strong code of practice. The hospital charged fees for non-resident patients and would often alert authorities and proceed towards deportation. However, because these midwives worked in the community, they were not subjected to the constraints of the hospital institution, and their autonomous practice allowed them to make the decisions around who they would serve. As midwives were paid a reasonable wage, they were able to fulfil their duty of care, which Bronwen had identified as the quality of their relationships and professionalism. Christine further indicated that the financial reimbursement supported midwives to provide services for women who would otherwise not have access. These were experiences they learned by working in the community.

## 7.7 Direct-entry Midwifery: Educating Midwives

Helen Clark recognised that if midwives were independent, they needed training to match. A taskforce was delegated to develop midwifery training programmes. Initially, there were conflicting opinions around the credentialing and, in the end, it was decided as a degree programme. Some consumers were opposed, citing that midwives would be constrained within a university system and that a preceptor or apprentice model would be more appropriate, as Jackie mentions below. Members of the home birth community understood the potential of institutional interference, be it towards patients or students, and consumers argued that they had the least to gain with midwifery education in the university structure.

*We made it a diploma because we didn't have the support of the women. Judi Strid was vociferous about it not being a degree. The 1-year stand-alone diploma for registered nurses, so we wrote that curriculum and there were 18 in that class. We had two and a half teachers, how about that? It was amazing, it was a 40-week course. We built in a continuity of care, an on-call system for them. It was the first one in New Zealand, and they had to do 16 women, we nearly killed them. It was a magical experience. The hospital midwives were supervising these students that came in with women in labour and into the postnatal wards to see them and visit the way the LMCs do. They were seeing the model in action, before we even had the model. Caroline Flint had been out here the year before, with her research about better outcomes for women with continuity of care. (Jackie)*

The education programmes were designed as woman-centred, continuity of practitioner model, and tailored to suit the students' needs in terms of placements. Jackie mentions Judi Strid, a long-standing Auckland consumer involved in health activism, who opposed midwifery education within the university structure. Her concern was that student midwives and the midwifery programme would be subject to the Ministry of Education requirements. The new programme designed the curriculum around the continuity of care model and, as Jackie mentioned, it was the students who modelled the new continuity of care model to the midwives in the hospital.

To support primary maternity, the curriculum was developed in support of the students and profession. The first few intakes of students of the direct entry programme were known to the home birth community, they had their own

empowering birth experiences and wanted to provide that style of midwifery to others.

*The direct entry midwifery courses started, a whole lot of home birthing mothers applied, like the first intakes were all women that we knew. Women who had had these fabulous empowering births at home and wanted to share that with other women so for the first 10 years at least, of the direct entry midwifery programme it was populated by women who were passionate about birth and about physiological birth, women who had had normal births. (Brenda)*

Jackie talks about the first intake of women into the direct-entry programme in Auckland. The majority of whom are still working in the maternity field. In the first programme, students had a 40-week course where clinical placements were well supported in the continuity of care model. As Jackie shares, this midwife-led model was unable to continue.

*We only had 18 students. We could put them with really experienced midwives both in the hospitals... with the very few community-based midwives that they were because there was really only Joan and Caroline Young and Sian Burgess and Rhonda Jackson working as domiciliary midwives at that point. So, they had a domiciliary midwife experience because the class was tiny, and you could do it. Yeah, I really hated it when they made us take so many students because they wouldn't listen to, 'you have to have good quality practice and to transmit good practice you need good quality practitioners, they are fewer than the bulk'. You can't just shove them out with any old midwife because you lose the knowledge, intergenerational knowledge and that's exactly what's happened, exactly what's happened in the last 30 years. I think as the classes have got bigger, the attrition rates were really high at the beginning and when we bumped up the numbers to beyond 50, was about the maximum that you could readily absorb into the service for proper supervision and clinical teaching, without burning the midwives out and without inundating the services in the hospitals. So yeah, it was really difficult, and of course that was a battle I lost of course because the economics spoke louder than the long-term goal of good quality practitioners. They didn't fall out of the programme because of those 18 women, only one of them fell out of the programme. The other 17 finished. That first intake, they are coming up for retirement now. (Jackie)*

Jackie outlines some of the concerns that Judi Strid had expressed regarding the direct entry programme being housed within the university institution. The students and educators were subject to university requirements, which included increasing the

numbers of students so that the programme was financially viable. Doing so applied pressure to the midwives in the community to take and train more and more students which, at times, diluted the educational experience of placements. As more students were enrolled in the programme and there were not enough placements in the community, the hospital was the only setting for students to obtain clinical requirements. Therefore, some students were less exposed to the philosophy which the direct-entry programmes were built on; that pregnancy through birth and postnatal are a normal physiological process that is managed through primary health services.

## 7.8 Conclusion

In a general sense, the cultural shift was set in law when Helen Clark proposed the Nurses Amendment Act, 1990, allowing midwives to practice independently from GPs. What followed was a large community shift of medically minded midwife practitioners flooding the community who did not have previous exposure to natural childbirth and the paradigm shift that the home birth midwives had experienced. Despite the influx of med-wives, the College continued the development of the profession supported by its founding members.

Participants indicated that midwives were highly regarded in the community and finally financially compensated for their work. They developed work streams to support the new profession and work continued by the College towards the unification of all midwife practitioners. However, because most obstetric nurses' experience was within medical institutions, they had not unlearned the medical model nor had they undertaken the process of relearning to trust birth and women, which home birth midwives indicated was required. The low intervention, women-centred model did not infiltrate the mainstream culture with enough force to impact any major shift in natural childbirth as the dominant model.

However, domiciliary midwives and women were successful in changing the legislation, securing better pay, autonomy, and an independent profession. The home birth community was responsible for the development of the frameworks for the New Zealand midwifery profession, successfully implementing partnership and woman-

centred care. Nevertheless, the mainstream medical model continued in some areas, and the home birth community was still considered different.

The metanarratives identified in this chapter reflect that the patriarchal hierarchy continued to influence maternity services with rigid protocols and embedded surveillance. In response, participants agitated for change. Making home birth accessible for women and increasing funding for midwives, these participants fought against the dominant social norms. Ultimately, they changed the system by increasing health literacy, and promoting births at home as an extension of the woman's domain where she was free to birth 'her way'. Participants identified dismantling the maternity system while at the same time dismantling and recreating themselves and their practice; linking back to the narrative category—learning, unlearning, and relearning: a practice shift.

The research question I set out answer within this chapter was: How did participants navigate their professional relationships with other maternity care providers, and what influenced these interactions? In terms of the interactions with other maternity care providers, their professional relationships with med-wives were fraught. Even within direct entry education, there were tensions in competing priorities of financial viability in a programme for a university versus what was considered a competent practitioner.

This chapter concludes the presentation of the narrative category around the learning, unlearning, and relearning of midwifery skills, and the early development of the profession. The chapter has explored participants' experiences of challenging the institutionalised, patriarchal structure of hospital-based maternity services through their radical action to educate themselves. By reclaiming birth as a collective, their efforts, through grassroots activism, illuminated the resistance and carved a new path towards a midwifery-led model centring the women. This chapter also examined participants' defiance of the system in regaining agency through childbirth 'my way'.

The next chapter focuses on the othering of midwives and how the Ministry of Health's failure to engage with the College of Midwives directly correlates to the continued midwifery shortage, a loss in continuity of care, minimised autonomy, limitations on informed consent, and an increase in over-medicalised maternity care. Also presented

in the next chapter is how large institutional othering is threatening midwives' reputations and withholding financial support.

## Chapter 8 Findings: Narrative Category - The 'Othering' of Independent Midwives

*It was just literally, 'We don't believe that a midwife can be unsupervised in the community and do the job because we don't trust them'. I think it was more to do with not trusting a woman's work force or the women to be autonomous. I think that's the underlying premise. (Karen)*

This chapter focuses on the narrative category—'othering' of independent midwives. The Cambridge dictionary defines 'othering' as: the act of treating someone as though they are not part of a group and are different in some way (Cambridge University Press, 2025). Although participants did not use this exact definition when sharing their experiences, it became evident in their narratives. Participants had been treated as 'different' by what I have identified as the 'institution' under which independent midwives worked.

In Karen's statement above, she is framing the undervaluation of women's autonomy and professional capacity, which aligns with the 'othering' narrative of systemic marginalisation. It highlights the institutional resistance to acknowledging midwives' competence, which was used to justify practices that undermined the profession and resulted in financial inequity. The participants explicitly linked misogyny and ingrained gender biases to their experiences of 'othering'. However, the metanarrative is that although the medical community argued mistrust and claimed safety as reason for not wanting midwife autonomy, their actual concerns were about losing financial control over maternity service payments. Indeed, even in 2025, they continue to fight against equitable payments for midwives.

This chapter presents the metanarrative of 'othering'. It describes participants' experiences of being treated differently by individuals within institutions, including the hospital and MoH. Participants also cited the example of the Ministry's refusal to collaborate with the College of Midwives. The definitions of 'institution', as they have been used within the analysis, include "'an organisation founded for a religious, educational, professional, or social purpose' and 'an established law or practice'" (Cambridge University Press, 2025, para. 1).

During the interviews, participants shared numerous experiences of being othered by educational, professional, and social institutions. They also spoke of being othered by the institution as it pertained to 'law or practice'. In this chapter, I interpret law as the unspoken laws which relate to an individual's behaviour. In the instances of independent midwives, this relates to their practice behaviour.

Historically speaking, within medicine, patients and midwives have been expected to exhibit submissive and subservient qualities (Tully, 1999). In terms of the institution, as it relates to 'practice', I interpret this as the medical institutional practice or, the medical model of practice (the med-wives and medical community) compared with the home birth midwife participants and home birth women.

In analysing the narratives of the midwife participants, an experience they all discussed was repeated exposure to negative treatment by doctors, media, the medical society and MoH, and even other midwives. When midwives were paid the same as doctors, between 1991 and 1993, the NZMA leveraged media platforms to shame midwives and erode public confidence in their practice (Gendall, 2001). Further examples of this issue have been presented in Chapter 7, and include: the negative treatment of being ignored, slandered, confronted with snide remarks; a lodgement of an official complaint by a hospital superintendent; or an official complaint to the Midwifery Council (Strid, 1988). Midwives operated independently and their work was consistently undermined by negative attitudes and a lack of collegiality, which impacted individual professional autonomy and the entire profession.

This chapter outlines a system failure beginning with the MoH in their neglect to appropriately integrate midwives into the maternity system. The Ministry never properly solidified the midwives into primary care. Instead, their enduring othering of midwives, set a precedent for the Medical Association, and the media to corroborate in abuse towards midwives. The Ministry, as the central funding body for health services, prioritised funding for hospital institutions, when primary birthing options are more cost effective and provide evidence of better health outcomes (Farry et al., 2019; Grigg et al., 2017; Rosenblatt et al., 1985). The story map grid outlining the analysis of the sections in this chapter sections can be found in (Appendix E).

## 8.1 Historical Precedence of Othering

*I must have been the secretary of the Domiciliary Midwives Society. I went to Christchurch and Barbara Brown was the Department of Health person who ran that process of renegotiation. And she said something about not paying for home births and I said, 'But why wouldn't you do that? Those are the births that cost you the least. We're keeping people out of hospital. They're taking all the overheads and looking after themselves. Why on earth would you then say to the midwife, 'Well, you're not going to be paid?' Anyway, they ended up covering home births. (Bronwen)*

Bronwen was the secretary of the Domiciliary Midwives Society from 1984-1995 (Banks, 2007). Barbara Brown may have simply overlooked the subculture of the home birth community to be included with the renegotiation, or perhaps this was an intentional exclusion, it is not outlined in Bronwen's quote. Domiciliary midwives were not being paid a living wage or even the universal minimum wage, which was introduced in 1894 (Starr, 1981). In relation to the concept of othering, the connection between women's work, inequitable pay, and society's enduring recognition of women as caregivers (Hyman, 2017) is crucial; the persistent undervaluing of this labour through inadequate remuneration is fundamentally tied to questions of power and control. Bronwen discusses seeking information from Joan Donley to understand the processes of attending births at home.

*I remember writing to Joan to say, 'I want to set up my practice in Nelson, how do I go about it?' And she wrote back and told me. So, then I went to the principal public health nurse, and I said, 'This is what I'm doing'. And it was, 'This is what I'm doing, I'm not asking you. I'm setting up my practice'... I just got some pinafore smocks to pull over a shirt and that was my uniform. She just needed to see it. And then she went through a period of wanting to inspect the places where women were going to give birth. And I said, 'No, you don't have to do that'. There was one woman, she [the public health nurse] insisted on coming, and after that I thought, 'Well, I'm not going to tell her. I'm not going to tell her who I've booked in'. And I was like, 'I'm the midwife. I'm the one that looks after that, that's not your job, that's my job'. (Bronwen)*

Bronwen touched on the over-reach of the public health nurse's presumed authority of Bronwen's practice. She continues to speak about how she would discuss with women if they needed something before the home birth; ultimately, to ensure a safe

living standard. In her description of the visits to clients' residences, she outlines her clinical judgement and assessments.

*I'd say, 'You need to get this in..You need to get that in'. But also, you take cognisance of how people are living, and of course at that time it was the great hippie explosion. So, people were living in house trucks, in run down shacks, they were living in all sorts of places, and I didn't care, that's where they were having a baby. If they hadn't had the baby there, they were bringing the baby back to that, so what's the big diff? Also, they're living in and amongst their own bacteria, so you take in all those things, really. So yeah, I was just very bolshy. It was like, 'This is my job you keep out of it'. (Bronwen)*

Although Bronwen describes herself as bolshy, which generally implies assertiveness and defiance, she has simply set the distinctions between her role as the midwife and the role and responsibilities of the public health nurse. Bronwen has been put in a position which was perceived by the health authorities as reckless and potentially dangerous. However, if safety was the actual concern, they would have been obligated to offer options to ensure what they considered an appropriate level of clinical support. However, they did nothing, apart from make attempts to bully Bronwen with surveillance to make her 'behave'.

In Nelson where Bronwen worked, there were no GPs supporting birth for women at home. Regardless, women continued requesting Bronwen to attend their deliveries. She outlines her reasons for providing services which were unlawful before 1990.

*The woman didn't have a GP, because she couldn't find a GP to support her in what she wanted to do. I read the Social Security Act that basically said you remain her care provider if she can't find somebody else to care for her. So, I started attending births where the woman didn't have a GP. I did that several times and eventually the Listener did a three-part series in the 80s about birth and home births and I featured in the second one. I just went, 'She couldn't find someone to support her where she lived, and she engaged me as the midwife. I had a duty of care, and she hadn't found anybody else to look after, so I had to go'. That's how I saw it. And I basically stood there saying to the Ministry of Health, 'Come on, take me on'. (Bronwen)*

Bronwen's philosophy was based on a woman-centred approach; she felt confident in the woman's ability to deliver at home with a skilled and experienced practitioner. As Bronwen continues, she justifies her perspective of challenging the Ministry.

*Because what are you saying? That women should give birth alone? Unaided? When in actual fact there is a person who can go and at least stand between them and death, them and their baby's death. Why wouldn't you support this? It doesn't make any sense. And it was a moment in time, but I took a stand. Yeah, I thought, 'Bugger ya. Bugger ya. How dare you impinge on my practice? Saying that I had to be supervised by a doctor. How dare you impinge on this woman's ability to do what she wants around giving birth to her baby'. It wasn't just about me. (Bronwen)*

Bronwen contends her decision to attend birth at home was 'not just about' her. This statement, while it may seem minor, is a significant differentiation between the medical and midwifery models. The home birth movement was one about collectiveness for women; whereas the dominant patriarchal model is grounded in individualism, highlighting the need for the doctor to perform a 'delivery' of the baby rather than the mother who births a baby.

Once the Act was changed in 1990, midwives were legally able to claim the same amount as GPs for their work (Ministry of Health, 1990). Under the law, independent midwives performed equal work to that of GPs in primary health practices (Guilliland, 1997). Norma describes condescending treatment and outlines the contempt she faced by other practitioners after the pay increase.

*'Oh so, picnic on the floor, is it?' Oh, it was horrible. At that time in the community, we were uppity or so that was the rumour, the impression of us, from what I heard. That we thought we were better. We never did, but it has been a hard thing to change and work through. You used to have to take your back-up with you, because nobody would talk to you. The consultants, they wouldn't talk to you, it was like, 'You wanted it, you've got it'. (Norma)*

Rumours created the perception that midwives 'thought they were better', which generated hostility towards them. Norma outlines a form of professional retaliation, deliberately withholding support or treatment to punish midwives for asserting independence. Susan had a similar experience of practitioner withholding assistance when she requested assistance in a hospital birth for the shoulder dystocia (section 7.5). Here, Norma indicates a consultant's refusal to collaborate, stemming from professional and hierarchical tensions. However, in both cases there is consistency in the lack of concern for the patient's medical needs. Additionally, Norma's statement reinforces the notion that doctors did not view midwives as colleagues but as

insubordinates needing to be put back in their place. This highlights that the argument was not actually about patient safety, otherwise they would have a duty to intervene, which did not happen. Midwives simply working independently, and collecting payment, challenged the dominant medical authority.

In contrast to Bronwen framing herself as bolshy, Norma's perspective was that midwives were being labelled as 'uppity'. This negative position of name calling distracts from what women are aiming to achieve when they challenge the medical authority. It intentionally reduces women to a socially unacceptable behaviour. It is a crucial distinction, as the participants in this section indicate; women who are seen as not behaving submissively are considered disruptive rather than accurately described as autonomous professionals performing a job for which they are trained. As Bronwen indicated, the movement was not just about midwives, but all women.

While participants spoke of being treated differently, the most profoundly damaging aspect of othering is the impact it had on the whole profession by individuals at the Ministry of Health.

*The Ministry has never come out and said, 'We support midwives'. You know, 'We love the police', but they never... For years we've said we need a national campaign, and that has to come from the top.*  
(Christine)

Collectively, participants expressed being treated differently than their medical counterparts, doctors. The MoH could have mitigated this issue, as Christine indicates. Instead, their silence contributed to the problem. Christine refers to a time when the New Zealand police were receiving negative media attention, and in response the Police released a statement to remind the wider public that the role of police was to protect the community. Christine's statement outlines that the Ministry could have made a broad statement on midwives' behalf.

Sian and Bronwen both identify that warm sentiments towards midwives were not felt within the Ministry. Instead, doctors were favoured, as expressed through prioritising doctors' pay and permitting hospitals to do the same.

Before the Nurses Amendment Act, the stigmatism of midwives was generally contained within medical environments, when domiciliary midwives needed to engage

with hospital staff. However, the home birth community was also exposed to media criticism, often having been tipped off by hospital employees.

*We learned never to engage with the media. If there was a poor outcome, never engage because they were only out to do you in. 'Unsafe practitioners', and 'Unsafe people'. There were some poor outcomes, but not just because they were born at home. (Marjet)*

Teenha Handiside, working under Helen Clark, was involved in the processes around composing the Bill, which changed the Act. She offers her perspective on the core aspects around the palpable animosity.

*It was just eroding people's boundaries. When we looked at what a midwife did and what a medical practitioner did, if you look at it on a cake, it's just a wee slice of difference, a wee smidgen of difference. The scope of practice was identical, but people are very tight about these things. The money was a huge thing and, well, nurse practitioners weren't big in those days either, so it was quite threatening when a midwife, who was then a nurse-midwife, could prescribe and access laboratories. It was just a preciousness about professions, the medical profession, in particular, was very tight. And I guess there hasn't been anything as challenging since then. (Teenha)*

After the Act, it became evident how 'differently' independent midwives who did not work for doctors were treated. When midwives could claim payments at the same rate as GPs, participants relayed that doctors were first affronted and then became aggressive. Norma elaborates on the shift in that professional relationship.

*That's why they fell out with us; it wasn't anything else. Because we actually financially challenged them and they were then paid the same as midwives for caring for a pregnant woman and not more than us, which they felt they deserved. The legislation changed overnight, and they were happy to do shared care with us for about 2-years after that change. Until they realised that the woman started going in for their pregnancy test and said, 'No. I don't want you, I actually want the midwife'. Or they just rang us directly and then just notified the GP and we'd say, 'We're looking after her' and they'd say, 'Well, she needs to come in for one check-up because we don't trust you'. It was so they could claim that general medical benefit. So, it did feel like it was all about money for them actually and really hurtful as we all felt we had good working relationships with them until this, but I guess we were threatening. This was a big deal for GPs at that time, maternity was a big income earner. They would see the women in the clinic, but they didn't do any of the acute stuff which was what midwives did. (Norma)*

Norma identifies a contradiction in the doctors' behaviour. Their withholding of treatment suggests that control and power was a more accurate driving force, than their argument of trust, behind their behaviour towards midwives and women. Many women around this time were not aware that they could simply contact a midwife and bypass a GP altogether (Fleming, 1995).

Between 1990 and 1992, many women continued to consult their GP to confirm pregnancy through a standard urine test administered by the practice nurse. The GP would then discuss the available options with the patient while claiming a standard consultation fee. Many GPs 'gatekept' by suggesting a colleague as the only option and neglected to refer to midwives. However, when women began opting for shared care between their GP and midwife, both practitioners were able to claim financial payment through the maternity benefit, which contributed to the maternity budget blowing out (Guilliland, 1997). Many participants discussed the budget blowout; however, it was the widespread rhetoric instigated by the NZMA which prompted the Health Minister's involvement.

This section demonstrates that the fight for professional autonomy was not just about clinical legitimacy but power and control over maternity service funding. The backlash from doctors was deeply tied to financial loss rather than patient outcomes as they previously held the monopoly in maternity services (Coco, 1993) and this exposed the economic motivations behind this retaliation. Furthermore, the erosion of collegiality between midwives and doctors reveals how financial incentives have shaped and undermined collaborative relationships (section 6.3).

## 8.2 The NZMA's Campaign of Defamation

*When it's midwives making mistakes, the medical fraternity tends to get out the daggers to crucify them. Generally, the medical fraternity was against midwives. It may have changed, and I am curious to know if midwives still feel that they are under pressure from the medical fraternity if something goes wrong. (Glenys)*

This section examines the New Zealand Medical Association's (NZMA) efforts to preserve its authority over maternity care and, by extension, retain control of the funding using strategic media campaigns that were designed to undermine midwives. Hospital institutions, which should have directed primary maternity patients to

community-based care, instead admitted them, reinforcing the misplaced perception of risk in labour and birthing. The Ministry of Health, as the funding body, failed to intervene. It prioritised doctors and institutions as providers of maternity services, to the detriment of both taxpayers and women in primary health.

For 2-years after 1990, GPs continued to claim maternity fees for an initial visit, or for a shared care arrangement between GP and midwife. Obstetricians claimed fees for their private patients, and hospitals received funding which they delineated for their employed staff (nurses, midwives, obstetric teams, and paediatrician), medications, and treatments. In 1992, the health budget was in the red, and the NZMA scapegoated the introduction of independent midwives as the culprits of a budget 'blowout'. Newspapers quoted NZMA representatives stating that midwives were to blame, providing only the fees of independent midwives (Fleming, 1995). The maternity budget, which is always set years in advance, had not been updated to incorporate the Act. So, while midwives' fees were part of the whole budget, they made up only a portion (Guilliland, 1997). The participants discussed aspects of the fiscal miscalculations. *"The doctors were just furious, weren't they? That we earned all this money"* (Christine).

The maternity budget was made public when midwives began billing for the same fees; midwives inherited the remuneration which GPs had been receiving for interventionist treatments, exuberant travel allowances, and double payments for both their office and hospital treatments (Coco, 1993). Susan outlines that the Ministry, as the funding body, did not specify which practitioner would be responsible for maternity services. Instead, they pitted midwives and doctors against each other to resolve their budgeting errors.

*Well in fact the budget blew out and that was when the LMC model came out. The Ministry of Health said, 'Okay, whoever's going to be in charge of this as the person that holds the money and doesn't matter if the midwife or doctor'. (Susan)*

Joan explains how much more money the doctors earned compared to midwives. She outlines how practitioners could maximise payments through fragmenting services.

*The midwives in the hospital just exited and they all became autonomous. Then they worked with obstetricians and the*

*obstetrician would be in charge and the midwife would do all the work. The pay rate was so amazing, and the pay was all based on per hour for a delivery. So, if you had a long birth, you could get a lot of money. Some midwives worked with an obstetrician, and they only did the birth, and they could do 8 or 10 a month and some of them, as we worked out were getting, at that time, nearly half a million dollars. And you could do that if you only did the birth, and you did a lot and the budget blew out. (Joan)*

When payment rates for midwives were corrected to align with doctors in 1990, it resulted in a very lucrative increase, especially compared with hospital salaried midwives. Joan also identified the major contributing factor to the budget blow out as being the increased expense to the whole system. When midwives worked for doctors, their role entailed only managing the labour in the hospital, which was more lucrative than working as an independent practitioner because the doctor provided the antenatal care. The midwives were paid much more for doing essentially what they used to when they worked in the hospital; however, this also perpetuated the subordination of midwives working under doctors and did not offer women the practitioner continuity.

As some of the newly independent midwives lacked experience providing comprehensive antenatal through to postnatal services, the budget continued to be drained by an over-delivery of institutionalised and medicalised treatments, not because of clinical need, rather because practitioners were not skilled in assessment and management of normal physiological labour and birth. However, the media scapegoated midwives as if they were responsible (Gendall, 2001). If midwives had left the hospitals to work independently and provide home births, the maternity budget would have been less than in previous years (Guilliland, 1997).

The hospital staff used surveillance to monitor practitioners, as Carolyn previously expressed, where she was told to keep an eye on Joan (section 6.2). The medical community used the subversive tactic of slandering domiciliary midwives' personal reputations to discount their professional practice.

*Years ago, I was appointed to the National Guidelines Group. I was the first midwife to be appointed. At the end of the 2-week workshop, you had to say the thing that you learnt most about each other. These two GPs said they'd 'Learnt that Karen Guilliland wasn't a two headed monster'. I think they thought they were complimenting me! There*

*were many insults over the years like that. I got hate mail, I got people ringing me up and abusing me. (Karen)*

The two GPs' remarks suggest that they held negative preconceptions about Karen before meeting her. More strikingly is how they appeared proud of having come to their own revised conclusion, rather than recognising how condescending their comments were.

While the Save The Midwives had developed print media for their cause, and used *Broadsheet* to spread their message, these mediums were in 'fringe' feminist spaces. The medical community used similar tactics; however, they used the mainstream media as their pulpit, with a strategy specifically used to slander the personal and professional reputations of midwives.

### 8.2.1 The Role of Media in Discrediting Midwives

*The Frontline programme 11 October was to undermine the midwifery model of childbirth and create public demand for safety protocols to protect women from midwives who don't use routine episiotomies. (Joan Donley, 1992b, p. 11)*

The rhetoric that midwives were responsible for the budget came from doctors talking to the media. Midwives were exposed to criticism in the public arena which was not defended by the Ministry. Sian explains how the media uses the notions of fear and safety which perpetuates the medicalisation of childbirth.

*I think you can't underestimate the power of the media. The media have not been kind to midwives. Look at the Sunday programme. Those exposé programs have an influence on the psyche of society and so there's that fear, because the media is drumming up fear that somehow birth is unsafe, and midwives are unsafe... I used to have a lovely poster from the UK London Underground, it was of a midwife holding a baby and it said, "we delivered the midwife". A poster like that wouldn't happen in New Zealand. (Sian)*

Sian mirrors Christine's statement (section 8.1) that New Zealand has never celebrated midwives. Joan outlines how the repetitive messaging permeated and influenced 'society's psyche', borrowing language from Sian.

*So, the papers would be rotating, there would be the midwives with the dead baby and then there'd be the social workers on the front*

*page and then the police and then we'd think, 'oh we must be ready for another midwife on the front'. So, then there was another dead baby again so there was this sort of rotating. It was a very interesting environment of not viciousness but just this blame, need to blame someone for anything that went wrong. (Joan)*

Andrea extends Joan's comments, although her statement purports the media being a catalyst for a process of inquiry. The media in consistent rotation, instigated a wedge in the partnership dynamic between consumers and midwives.

*A maternal death or baby hit the media big time because it was midwives and because it was new. So, we suddenly became aware of that fear of going to the letterbox to see, God is there going to be a letter there from authorities [or] from Nursing Council saying, 'There's been an inquiry'. It would be the same today with the Health and Disability Commissioner. Somebody put in a complaint, and some midwives around that time almost gave up or did give up. So, in all that time we've gone from being midwives, the women, the GP, all sitting around on the floor in the living room together. Then all of a sudden, it felt like we were no longer together no matter what. (Andrea)*

Some of the participants identified that before the Act, consumers and home birth midwives had stronger bonds. However, as Andrea notes, the media utilised a unique divide and conquer approach to sever the midwife/consumer partnership. Christine identifies how intrusive reporters became simply to capture headlines, "*We had reporters in the trees in the Hutt outside delivery suite trying to get pictures of one of the staff, it was pretty bad*".

In instances where the media published salacious articles about a bad birth outcome, the intention was to sell headlines and assign blame. The story being sold was that of the 'negligent midwife'. Carolyn identifies wider issues of maternity services which are not included in the articles.

*Many cases had headlines, and I would think, 'I wonder how long that midwife had actually been working', and 'Was she doing the newborn check when she'd been on her feet for 23 hours?' It's not just getting out of the hospital door; there were midwives who had road accidents on the way home from prolonged labour and it had been impossible for them to hand over. No one was willing to relieve them and that was sometimes just carelessness on the staff's part because they'd be doing internet searches for personal things, but not free to relieve a midwife who's been on her feet forever. But there were other times*

*when they were really stretched to breaking point and could see that and a midwife had been there way too long and was exhausted and was desperate for her but couldn't relieve them. I did find that midwives that were out in independent practice and then moved into the staff midwifery employment, they were the ones that would come to knock on the door and say, 'Do you need a break?' So, part of it was just the work demand was really, really hard. (Carolyn)*

While news reports often frame midwives as negligent, dangerous, or irresponsible, Carolyn highlights broader systemic issues contributing to real concerns; namely, being overworked, lack of adequate staffing, and unsustainable working conditions. This quote also suggests that when a poor outcome is reported, public perception of midwives is shaped by incomplete information. For example, not including information about staffing shortages or the length of time an independent midwife had been working. However, what Carolyn has not indicated is that the medical community, by way of the Ministry, the hospital, or medical doctors, could have acted in a collegial way by offering support rather than criticism.

Suzanne discusses feeling responsible to correct misrepresented ideas about midwives when representing midwifery in her other professional capacities.

*I suppose that really brought sharply into focus for me the perception that other professions had of midwifery. That initially spurred quite a defensiveness in me but then I saw it as an opportunity to be a voice for midwifery in that context. So doing lots of case review work, that's when I began to see that disciplinary processes are not necessarily about judging and punishing, but it made me think about where midwifery fit in that bigger picture. And how it was possible to influence and correct people's thinking about midwifery. Because, I hesitate to say this, but there is a lot of deficit thinking among other professions about what we do... There are a whole lot of other things which are irritatingly called 'soft skills', for what midwives do... A lack of understanding about the breadth of what we do and the depth of our education. People make a lot of assumptions about what midwives know and don't know. How research and evidence based our work is, and that's absolutely one very important facet about midwifery, is being evidence based. But whose evidence counts? (Suzanne)*

Suzanne continues to discuss educating individuals in other professions that have believed the negative media about midwives. As a representative of midwives, she is alone on this committee to correct the reputational damage which has come about

from the media and has not been corrected, as Christine mentioned (section 8.1). The higher authority, the Ministry has not spoken out in favour of midwives, leaving individuals, like Suzanne and Karen (section 7.3), to correct others' opinions.

*So, I began to understand the social narrative about midwifery was undervalued and what people in those spaces needed were midwives who were knowledgeable, capable, and articulate, and able to challenge... I remember being in one review where somebody had had an induction. Things had not gone well, and everybody was really focused in on the decisions made along the way. And I said, 'My concern was why this person was being introduced in the first place. There were no indications except for a date. She was a really well person and had this induction which really unravelled her process. And my question was why? Don't be thinking about and focusing on what's happening here. Let's look back at the decision that was made about that person having an induction. Because it all spiralled out of the intervention'. So, those were little moments where I recognised that my fundamental beliefs were actually being challenged by their process. Which was not questioning the genesis of where those problems occur. It's just looking at what happens in the moment without backing up the bus and going, 'How could this have been avoided?' That would probably have been avoided if the decision for the induction hadn't been made. (Suzanne)*

These passages highlight the public and professional misunderstandings that contributed to the erosion of midwives' professional reputation. When negative opinions about midwives circulate, whether through news coverage, disciplinary processes, or professional biases, they reinforce misconceptions about a midwife's competence, education, and role in maternity care. Suzanne describes 'deficit thinking' about midwifery, which reflects a broader societal tendency to undervalue midwifery. In diminishing a midwife practitioner's strengths to 'soft skills' as compared to the scientific approach, the deficit of these skills is highlighted rather than recognising the importance of these skills in clinical situations.

Suzanne's perspective also illustrates how midwives are the focal point and scrutinised after an adverse outcome, rather than questioning the medical practice and technological decisions which led to those outcomes in the first place. She demonstrates how the dominant medical model is revered as faultless and, therefore, a bad outcome equates to the midwife being in error and reinforces blame. Marjet continues this thread in section 10.2. However, the lack of clinical indication for the

medical induction of labour remains unquestioned. In addition, midwives are left to individually correct these false narratives, which contributes to their perpetually increasing workloads.

Teenha and Tamarin identify the result of media's influence and the narrative it perpetuates around people's perceptions which, in turn, affects both midwives and women's behaviour, and, ultimately, their 'choices'.

*The point that Helen Clark made was it's all well having legislation, but people have got to change, not just the legislation. People are very loathed to change... The next generation of women would say, 'I want my daughter to have the best. We'll pay for her to go to an obstetrician'. And I would say, 'That could be very detrimental for your daughter'. And they'd answer, 'Oh, no. She doesn't need to go through what I went through. No, she can have a caesarean'. So, you see, its ignorance, its ignorance that pays the medical profession. And they're the ones that benefit, not the women. (Teenha)*

Tamarin outlines the process of how the media controlling the psyche of social narrative. She identifies that this type of fear mongering would have been addressed by Joan Donley, if she were still alive.

*I've seen it happen too, midwives have got scared and then woman get scared because, if you look in the media that cycle; they're on a witch hunt again. They vilify the home birth midwives because, 'You can kill babies having them at home'. It comes in a cycle right in the media. So, the fear is huge, and they don't have anyone to go to like Joan to actually put that in perspective for them. (Tamarin)*

This section outlined how derogatory media stories have negatively affected the professional reputation of midwives within broader society leading to the unfair scapegoating and othering of midwives, regardless of culpability.

### 8.2.2 Maternity Benefit Tribunal, New Prime Minister, and Payment Restructure

*After our 1993 win for [pay] equity many in the Ministry of Health have had an anti-midwifery stance pretty much ever since. And by 1996, they completely changed the whole funding model and reduced midwives' income by 30%. We only had 3-years of equal pay! The undervaluing started with the domiciliary midwives, paying them \$2.00 an hour and treating them like absolute shit. (Karen)*

Karen expresses that institutional 'othering' has been around for decades. Paying midwives less for equal work and equal responsibility, reinforced the marginalising within the wider healthcare system. In 1992, the Minister of Health, Simon Upton, established a Maternity Benefits Tribunal to consider the restructure of maternity payments after the budgetary concerns. The NZMA had a history of unwillingness to accept the Department of Health (DOH) recommendations on maternity care payments (Coco, 1993), they demanded a tribunal by boycotting meetings with midwives and the DOH (Donley, 1999). The tribunal was made up of five members and included midwives representing the College. All previous tribunals had only had members from the Department of Health and the NZMA. The hearing lasted 7-days, and testimony was heard from 11 obstetricians, 5 midwives, 2 economists, GPs, and paediatricians (Guilliland, 1997).

Norma explains the payment system, prior to the Act, and identifies what the Tribunal outcome meant for midwives.

*The GPs claimed the general medical benefit; we couldn't claim it. I went out with a group of midwives in 1989 so before the legislation changed, we were able to do one antenatal visit and one postnatal. You could go to the Medical Officer of Health and plead for the ability to care for women postnatally, and how many women do you want to care for. I said, 'Well I don't know. We'll just see how many need us'. It was all these terrible breastfeeding problems, and you got nothing, there was no real money, and we weren't allowed to have the general medical benefit at all. So, the claim in the Maternity Benefits Tribunal in 1993 legislation was around 'equal work deserves equal pay' and that actually, midwives did the same as GPs. (Norma)*

The NZMA argued for separate pay schedules for doctors and midwives and was denied (Christison, 2001). However, some of the Tribunal recommendations were not upheld by the Minister of Health, which would have benefitted doctors more than midwives. The Tribunal proposed to increase the initial consultation fee by 26% and reduce the labour fees, mainly billed by midwives, from \$139.60 to \$52 an hour (Christison, 2001). Overall, the Tribunal accepted midwifery education was sufficient, midwives practiced safely and ruled that midwives performed equal work to GPs and, therefore, upheld the pay at the same rate.

*The Tribunal found that we, midwives, did work of equal value; they didn't do it quite the same way as doctors, but it was work of equal*

*value. The medical profession and I should be paid the same rate. Well, very shortly after that the leading Department of Health renegotiated the whole contract around maternity, and they modularised it. (Bronwen)*

Although the 1990 Act allowed midwives to work independently from GPs, the NZMA retaliated because of the financial loss to earnings due to market competition and consumers making a different choice around their birthing options. A General Practitioner Action group was formed. Despite only 15% of GPs at that time offering maternity services, they all took up arms claiming, “today maternity care, tomorrow general practice” (Donley, 1999, p. 17).

*Somewhere in the 80s, Karen and I were both part of a working group at the Ministry of Health led by a GP and it was about the care required for a woman having a baby, it was just sort of like the standard care for a normal pregnancy. We did a lot of work on that. And that I think was the basis of the modular system. We were quite happy to go along because I mean, we can see that if they keep paying us the way that they'd paid GPs, which, they were paid enormous amounts of money for nothing, pretty much, that it would just spin out of control and so we were totally open to it all being amended. (Bronwen)*

The College recognised that with the huge pay increase, coupled with the many midwives coming out of the hospital to work, the budget would be overstretched. Karen and Bronwen, knowing the anticipated expenses around the maternity services, they ‘did a lot of work’ to assist the Ministry of Health to create the ‘basis of the modular system’. The College came to the rescue by offering to aid the Ministry in what was, effectively, determining a pay cut of practitioners’ salaries. This was to benefit the wider health system in becoming more balanced economically. Bronwen further outlines the reaction from GPs; a sentiment maintained by some GPs in 2023.

*Well, the doctors thought their throats were being cut. Because that was the introduction of the lead maternity care system where the Lead Maternity Carer was responsible for the care. And so you got paid a modular thing. And they [the GPs] just wanted it all. It's really interesting listening to doctors who weren't even born when all this happened who just want it to go back to the way that it was. ‘Well, it was never like that for you. So, what are you talking about? Where are you getting the information from?’ And so, still, there's all this foment amongst the medical profession about these dreadful*

*midwives and how we push them out of birthing and all that sort of stuff. So that's been going on forever. (Bronwen)*

Women began engaging midwives instead of doctors, with a shared-care option between 1990 and 1993. Paying both practitioners was an unbudgeted expense. As a mechanism to increase their payments, the medical fraternity argued that pregnancy implies medical risk. However, due to the Midwifery Standards Review process, midwives had evidence of better outcomes in midwife-only versus shared care arrangements with doctors (Pairman, 1996). Joy, representing as a consumer of maternity services, was involved in financial negotiations.

*Pregnant women [started] realising, 'Oh, okay, if you want a continuity of care arrangement, then your Lead Maternity Carer is going to be a midwife'. And then observing GPs kind of bowing out of maternity. Some of them with very good grace and others with not such good grace. So, there was a bit of sadness and bitterness and a chip on the shoulder for some, and for others they were like, 'Absolutely, it's all good'. So, it was a pretty interesting time. (Joy)*

In 1993, with a change in Government, Jenny Shipley became the Minister of Health. With hopes to reform the public health service she opened dialogue around maternity funding schedules.

*Then of course Helen Clark was voted out and Jenny Shipley came in. She was okay actually over the pay equity discussions with doctors in 1993. She came in behind us when we took the doctors to the Maternity Disputes Tribunal and said, 'We want to be paid the same as them if we're doing maternity'. And we all sat down, and the doctors were being obnoxious, horrible. And Jenny Shipley said to the NZMA, 'Actually I just think you're telling lies. You need to get out of this room, go away and talk amongst yourselves and come back here with the truth' [knocks her knuckles on the table 3 times]. And nobody else has ever talked to the doctors like that. And I said to her, 'Oh we could do this, can we do that?' And she said to me, 'Karen, I am one woman in the Caucasus with 19 men, there's not a hope in hell'. Interesting, isn't it? In the end, it's all about misogyny at every level. Every one of those women ministers experienced it, and everyone at the decision-making level at the Ministry of Health. (Karen)*

The National party then appointed Bill Birch to Health Minister, and he sought further advice from the Tribunal. The outcome resulted in reducing fees for the initial

maternity consultation visit by 10% and increasing the labour fee to four times what it had been, in favour of midwives (Christison, 2001).

In 1993, Section 51 of the Health and Disability Services Act was developed (Ministry of Health, 1996). The NZMA came to the first negotiating committee meeting, claiming that, “the Nurses Amendment Act was the root of all evil in the maternity services” (Donley, 1999, p. 18). They were adamant that the payment schedule should continue as it was, with them to retain control of the funding. Sian outlines how the College engaged in the negotiations.

*I remember with the Section 51 negotiations, it was Karen Guilliland and Sally Pairman, me, Anne Yates, and Sandy Grey, doing most of the negotiations. We would do a lot of work; the College was a nascent organisation at that time. We shared rooms and we'd often have five of us bunking down in one hotel room with two beds and pulling the mattresses off the bed and someone's on the sofa and we would work really hard together, to be really well prepared for these meetings. Then you go down to the bar and the obstetricians, GPs and the radiologist were all in the bar drinking up large and were honestly unprepared for the meetings quite often and just assumed that their social standing would make sure that we would never have the equity that we ended up with. (Sian)*

Sian commented on the doctors 'drinking up large', anticipating their privilege and social standing would default negotiations in their favour. Although the verdict was upheld that midwives were entitled to equal pay under the legislation for performing equal work, it was short lived (Donley, 1999). Joy shares her experience being around the negotiation table.

*There was the funder, a midwife, me and the general practice side. The general practice side was not like how I've described my own GP, Murray Shore. The GPs on the negotiating committee, they weren't like that... they didn't have that level of awareness. They were coming out with these things, and they weren't even aware, they would say like, 'Oh, I know when there's a midwife involved, the mothers get more smiles'. So, there was an old-fashioned-ness about some of the GPs on the other side of the negotiation table. And it was a bit gritty, in terms of, this was the beginning of the realisation that when the penny drops, women will choose midwives and not all GPs. So, the negotiations were tense at times. But there was a willingness on the side of the funder to problem solve and look for new ways of doing things. To listen to everything that was arriving, but it was intensely political. (Joy)*

This section presented examples of midwives being othered by the Department of Health and outlined that doctors' behaviour became aggressive towards midwives when they feared losing financial control of the maternity budget. The NZMA used the public medium of the news to perpetuate negative press towards midwives to regain their financial standing (section 8.2.1). When pressure was applied to the government, they called a formal tribunal to advise on maternity payments. When doctors still did not achieve their desired result, the new government reconfigured the whole payment system. In addressing the funding issues, Simon Upton spoke to midwives at their annual conference, saying "the current arrangements for funding maternity have led to rivalries and poor communication. They have hampered integrated services between the main primary providers GPs, obstetricians and independent midwives" (Upton, 1992, p. 14). The next section outlines the hostility that participants were confronted with while working within the Ministry.

### 8.3 The Ministry of Health's Cultural Toxicity and the Impact of Othering' on Midwives

*We didn't have anybody in the Ministry that wanted to help us. Everybody wanted to bring us down-the hospitals, everybody. (Karen)*

Karen expressed an overall frustration that midwives were unsupported, highlighting the impacts that institutional patterns of 'othering' had on the profession. Participants recalled incidences of othering from individuals employed within the Ministry of Health and in hospitals. Othering was further evident when participants discussed insufficient support from the MoH in their role as the funding body which, over time, has caused irreparable damage to the profession as a whole and some participants in particular. Temporality and sociality have been used to describe the context in which different forms of financial withholding have been used against the midwifery profession from 1996 until 2023.

Bronwen worked in the Ministry of Health as a midwifery advisor for over 20 years. Within the first years working there, she found a dossier labelled 'Bronwen Pelvin'. Once when she was a domiciliary midwife, she was summoned for a talk with the Medical Officer of Health.

*They did talk in the Ministry of Health. I did find something when I worked there, some dossier or file of what they were going to do about, 'this terrible midwife down in Nelson'. It was definitely something like that. I read the report at the Ministry of Health, I thought, 'Oh, yeah. That was when the Medical Officer of Health was told to go and sort me out'. I'm sure that's what happened, 'Go and sort that woman out. Stop her from doing these silly things that she's not supposed to do'. And I thought, 'I'm not going to be sorted out. What? Not attend women having babies? Hello, that's my whole job. That's what I've trained to do for years and years. I've got all this experience. Why wouldn't I do that? Just change the law'. (Bronwen)*

Bronwen's sentiments indicate that midwives were viewed by the Ministry as transgressors needing to be corrected. She challenges the irrationality of the Ministry's attempt to limit her work, and her actions expose the contradiction in their logic; how can maternity care remain safe while the establishment is simultaneously trying to stop experienced professionals from attending births? She had written about the first 'illegal' home birth in the Domiciliary Society newsletter, explicitly stating that, from her perspective, she had done nothing wrong. The GP that refused to attend was abdicating responsibility. By the 1980s she had been a domiciliary midwife for 10 years, noting she

had discussed the situation with the medical officer of health; the Principal Public Health Nurse; a lawyer who is also a home birth father; even my friendly local obstetrician. All very sympathetic; none of them willing to provide the necessary legal back-up. (Pelvin, 1988, p. 9)

As Brown continues to share her compelling experience, she illustrates the punitive measures, surveillance, and coercion by the powers that be to enforce compliance. Bronwen's resistance was met with institutional retaliation.

*I was invited to come and have a conversation with the Medical Officer of Health about something I don't remember. Obviously, I had done something. Maybe it was around the time that I was attending births, and I said, 'Well I'll be bringing a support person'. So, I brought my friend Heather who was part of the Home Birth Association, and we arrived, and the first thing they tried to do was separate us. And I said, 'Well, I'm not talking unless she's here'. You know, like, 'I need a witness to what's happening here'. And so eventually they did interview me with her, and I can't even remember what the issue was. (Bronwen)*

Othring was a tactic used by those in positions of power to tarnish midwives' reputation and attempting to put them in their place to suppress their uprising. Calling Bronwen into their office, rather than going to meet her in the community where she is based, reflects the attempt by authorities to retain the hierarchical and institutional power dynamic. Separating Bronwen from her support network, Heather, is a gesture to weaken her ability to challenge authority. By insisting on keeping her support person, Bronwen resists the coercive situation, ensuring transparency and resisting being subjected to private intimidation.

Finally, the fact that Bronwen does not recall the specific 'issue' leading to the events indicate that the meeting was not about safety concerns, rather it was a broader attempt to control her through intimidation to which the Ministry did not want a witness. Furthermore, the question remains, why did the Ministry retain a copy of the dossier? As Bronwen suggested, reading it did not provide her with further insight into what the inquiry related to.

Sian identifies the institutional biases at play which prioritise the medical model and have continued the othering of independent midwives.

*There's been this real tension while we had right wing governments. They've not been particularly interested in negotiating with the College that is seen as a left-wing feminist organisation. And who they've got in their ear and they're very closely aligned with is the doctors who work within the Ministry and medicalisation who are like, 'How can we get rid of them? How did we allow the situation to occur when we've given 'these women', midwives so much power?'*  
(Sian)

In the late 1990s, after many years of working as domiciliary and independent midwives, several participants transitioned into roles where they contributed to policy development or provided advisory expertise within central government, particularly at the Ministry of Health. Bronwen and Sian reported that the culture within the Ministry of Health showed preference for the medical model over midwives, and this became evident within their narratives. Sian recounted years of exposure to negative comments about midwives and echoed Bronwen's comments, noting the Ministry's palpable aversion in their duty to financially support midwives.

Sian recounts attending a job interview for a role within the Ministry of Health, during which the hiring manager made a telling remark. The interviewer referenced Sian's 'reputation', to imply that her perspective would inherently differ from that of the Ministry. While the comment may have been an attempt to reproach Sian, it reveals deeper attitudes toward midwives.

*Most of the women [working] in the Ministry who were childbearing age were going to obstetricians and having that sort of birth, and it was a surprise to me. When I was first interviewed, a woman said, 'Your reputation goes before you Sian, you need to know I've had two caesarean sections, both my children were IVF, and I didn't breastfeed either of them. I don't want to have any more conversation about it'. (Sian)*

While Sian was successful in obtaining the role, it seems that the interviewer's forthcoming personal history was intended to set a boundary to control the conversation, assert authority, and signal a power dynamic at the first opportunity. Sian's statement reflects wider institutional bias within the Ministry identifying their counter-metanarrative; they have prioritised the medical model as a paradigm for maternity services (section 8.3.1).

Bronwen worked in the Ministry as an advisor and supported independent midwives' integration into the wider health system. However, she was surprised to learn that part of her role was to explain to her colleagues how independent midwives fit within the healthcare system. It was evident to her that individuals within the Ministry neglected to understand how midwives worked as autonomous practitioners.

*Midwives are just based in the community, they are self-employed, just like doctors. 'But they're not doctors, how can they be self-employed?' So that was still all part and parcel of the whole culture of the provision of maternity care and there was quite a lot of work to try and get midwifery integrated. (Bronwen)*

There is a sense in her statement that the 'misunderstanding' about the midwife's role was intentional. Bronwen began her work at the Ministry by integrating independent midwives into the Ministry structure. It seems that prior to that point, the Ministry was not cognisant of independent midwives, which speaks heavily to the 'othering' narrative. Language and payment schedules needed to differentiate between primary and tertiary care in maternity services. However, hospitals continued to overreach in

their service delivery by accepting primary care patients instead of focusing their specialised scope in admitting secondary and tertiary care patients. The Ministry, as the funding and policy entity, should have intervened to differentiate, for all practitioners, obstetric-funded hospital services versus primary maternity services.

*The Ministry, the more hands-off it could be the better [for them]. It just devolved stuff to the [hospital], pushed it back to the [hospital] all the time. So, when you're looking at maternity, even though they're paying the independent midwifery workforce, their biggest cost in maternity is what's happening in the [hospital]. (Sian)*

The Ministry's hands-off approach, consistently deferring responsibility to hospitals rather than enforcing clear distinctions between primary and specialist services in maternity. Instead of intervening to delineate boundaries, the Ministry allowed hospitals to dominate service delivery; thereby undermining the intended primary health structure. This approach pitted maternity service providers against each other, each fighting for their financial share. With hospitals and doctors seen in the media as the dominating model (section 8.2.1), they receive a larger portion of the maternity budget, which was earmarked for primary health, as intended by the Act.

Sian continues, indicating that individuals within the Ministry displayed contempt for the entire profession of midwives. She outlines a prevailing vitriol towards midwives.

*I worked at the Ministry for 20 years and I was appalled at the conversations about midwives. And more generally what I noticed was amongst my colleagues at the Ministry, very rarely was there a positive response to midwives. Midwives were seen as practicing outside the system, not to be trusted. (Sian)*

Sian notes that midwives were viewed with scepticism, not to be trusted, not credible, and rarely a positive response to them. In doing so, she identifies a strong undercurrent of othering, dismissiveness, and ignoring. Although Sian proffers that conversations about midwives were negative, the Ministry's behaviour of financial withholding reveals their attitude towards midwives.

*I think Bronwen did the most phenomenal job but never really had a voice and never had a budget. When I worked in the Ministry, I had a budget of seven million, but maternity has never had a budget. You've got no teeth if you've got no money in that type of environment and midwives are just seen as not credible. (Sian)*

Sian experience was that Ministers refused to work with the College, which impacts the midwifery profession. The funding authority, the Ministry, in their neglect to provide maternity a budget, economically subjugate midwives.

*There would have been a couple of ministers who really refused to interact with the College of Midwives and if they refused to interact with the College, then the College has got no teeth. The College has got midwives going, 'Why isn't the College doing A, B, and C', but the College just can't get any traction. So, the desire to mitigate reputational damage is huge because you want to be seen as credible, so you can represent midwives well and that's been made incredibly hard really. (Sian)*

Sian has expressed witnessing financial neglect from the Ministry. She has identified that the Ministry has institutionally deprived their own midwifery workforce by not providing a budget. Concurrently, they have refused to uphold their responsibility in liaising with an entire professional body. Alison explains the Ministry's justification to the College of their financial withholding and their attitude; rather than celebrate achievements, they attribute blame.

*Midwifery services have been framed like, 'Well you're just looking out for the white, worried, well because all the outcomes for these people over here are so terrible. And therefore, you're not doing your job properly'. And every health service cannot fix the inequitable outcomes that we've got, based on years of problems; they're not about one practitioner, one type of service fixing that. And there's sort of this laden expectation that somehow this magic, because they believe in the magic of what the midwife can do, 'But if you're that magical why can't you fix that?' And that's a very naive and a blinkered view. It's really frustrating because there's plenty of evidence that this model actually lifts inequities as much as you possibly can, within what the service can offer. It can't solve everything, but you've got a far better opportunity to engage people who are hesitant to come to healthcare, if you've got a trusting person walking with you. (Alison)*

Alison shares how midwifery is simultaneously both idealised and undermined. The indication that midwives only look after the 'white, worried, well', implies that pregnancy and childbirth is a primary health service and, like the well child services, are managed outside of the hospital system. However, the Ministry develops their own budget to segregate health services and in many areas of New Zealand they allow

hospitals to provide tertiary services for these 'worried well' patients and increasingly over-medicalised childbirth.

Alison indicates that the Ministry holds contradictory beliefs that midwives are so effective and have an "*expectation that, this magic*", that they should be able to single-handedly eliminate inequitable outcomes. However, when midwives cannot achieve these unrealistic expectations, they are further penalised. Midwives are being set up to fail. Alison's statement indicating that midwifery is magic, while at the same time identifying that midwives cannot perform miracles, is evident within the Ministry's questioning of midwives' legitimacy.

*When we did the Section 88 work, there was a whole lot of research that the Ministry of Health did that showed that we actually reached more Māori women than any other health service. I think it was maybe about 77% of Māori women we looked after about 20% more than any other service and a lot more than some other services. And so instead of saying, 'Well okay, how can we help the midwives to get the other 20%?' It was, 'No. No. No. You don't reach 100% of Māori women'. (Karen)*

Section 88 is the contract which pays for midwifery services. Alison and Karen express the contradiction within the Ministry of Health's justification for not increasing their pay. They reveal a deeper structural bias, institutional hypocrisy, and deeply negative attitude towards midwives as ulterior motives for their refusal to increase funding. "*Midwifery is part of the equity thing because it's a woman's profession, we are deserving of equity they don't see that bit*" (Karen).

The Ministry has a long history of perpetuating a negative culture of othering of midwives. As reflected in participants' transcripts, the Ministry of Health is made up of individuals who have ingrained personal narratives supporting medical practitioners and the medical model of childbirth. The Ministry has not intervened to delineate primary versus tertiary levels of care. Perhaps if they had dissuaded hospitals from collecting payment for service delivery of primary care patients, they would have the funding available to prioritise primary health and independent midwives.

### 8.3.1 The Ministry's Perspective in 2023

To obtain a perspective from someone within the Ministry, I interviewed an individual who had been working in maternity services for some years. They consented for their name to be published; however, I have chosen not to identify them. Due to the historic blaming, rather than accountability, my intention is to minimise any potential retaliation which may result from their comments in this section.

In 2022 a health reform restructured all maternity services under the new Te Whatu Ora (Health New Zealand). At the time the interview was conducted, in 2023, the participant affirmed the sentiments of participants Bronwen, Sian, Christine, Karen, and Alison regarding their experiences of the Ministry's attitude. It was apparent that less than positive attitudes towards midwives have continued.

A counter narrative which differed from that of the participants was identified. A heavy current of blame was present. In the interview I sensed strongly that midwives were being portrayed as responsible for all the shortcomings in the maternity system. The Ministry's strategy was to correct midwives' behaviour by implementing a series of undisclosed 'accountability' measures. Yet, the Ministry prided itself in (theoretically) full support of primary birthing while laying blame on consumers for not taking up the option, relinquishing themselves as having no authority to become involved.

*I think what's happened is that a little bit of poor behaviour happens, nobody gets challenged on it and they go, 'Oh well, they're getting away with that'. I don't think this is bad people doing bad work, but we have very few accountability measures. In fact, we have virtually no accountability measures within the notice, so without accountability measures and a 'fees for service' model that is modular, we have created exactly what was written down, which is not what anybody intended. We have displaced autonomy as, 'You are responsible for your decision making', which every midwife in this country is autonomous whether they are employed or not, to, 'I get to do what I want, when I want, and to whom I want', and that's what we've deemed autonomy to be and it's not. That was never what autonomy was meant to be. It was about not having a doctor tell us what we had to do. It doesn't breed collegiality, and we've made ourselves too important in the maternity journey of women. Even saying we're in partnership, we put ourselves in the centre.*  
(Anonymised)

This perspective indicates a tone that what independent midwives require are compliance and punitive measures at the Ministry's discretion. When asked for specific ways that the Ministry supported primary birthing, the participant deflected a response, indicating that it is midwives who are responsible for all issues surrounding maternity. The Ministry appears to be reluctant to do anything to support midwives in promoting primary birthing.

*I would say categorically the Ministry of Health has always supported primary healthcare as being a priority, with limited ability to influence personal decisions. (Anonymised)*

When pressed to further identify the causes of sustained dominance in medically managed childbirth, the participant identified women's personal choices as the culprit.

*That's what it comes down to. It actually comes down to, the lived experience and exposure of families having babies and what they expect from the health system. So if they expect, because all their friends and their sisters and everyone went into hospital to have their babies, and there's that medicalisation of childbirth that we absolutely know has happened and continues to happen. (Anonymised)*

Although there was an acknowledgement that some women desire a highly medicalised birth from the outset, there are contradictions. On the one hand I was told that the Ministry can do nothing about personal choice; on the other hand, I was told that people are not sure what they want, despite hospitals being their only option.

*There are very few women who say, 'Nah, I want to birth in a tertiary hospital, have my epidural at 9:00 AM and my caesarean section by 10'. That's actually not what you want, but when you remove choice, they think that's what they want. (Anonymised)*

This statement suggests that when women lack genuine choices in childbirth options, their belief is that they desire a highly medicalised birth experience, such as a scheduled epidural and caesarean section. However, this perceived preference stems from the absence of alternatives, leading consumers to conform to the limited options available. In essence, the lack of choice influences consumers' perception of what they want; thereby aligning the choice made with the only options presented. At the same time, the Ministry has not taken any accountability for their own contribution in limiting primary birth options for childbirth. Rather, they seem to focus only on

scapegoating midwives as the sole factor responsible for primary birth spaces being limited. Sian presents an example of a time when the Ministry did involve themselves with funding to reduce the number of ultrasound scans women were having and decrease the budget.

*They did with scanning. Some women were having 25 scans, and the average number of scans women were having in pregnancy was five. So, there was a real drive to think about what we can do. I was on that group with Bronwen. I think it was two or three completely funded scans so every woman would have an anatomy scan, and every woman would have a nuclear translucency scan as part of screening for Down's Syndrome... So, those two scans would be funded... For women the scan is about getting a picture of your baby [but] it's actually a medical procedure. So, they did try to reduce scans. (Sian)*

This account highlights that when the Ministry decided to become involved in the choices that consumers were making, they implemented a policy whereby they would fund only two or three scans, any further scans would need to be individually paid for. Thus they are aware that they have the ability and authority to change 'consumer' behaviour. The underlying implication is that medicalised hospital birth has become the dominant birthing model; and women internalise it as their own choice, rather than recognising that home birth or birth in primary units are equally legitimate. As the dialogue with the Ministry employee continued, primary birthing is acknowledged.

*I can hand on heart, say every single person in the national office wants to increase primary birthing for all the reasons when it is much cheaper... it's actually much better for outcomes across the board. (Anonymised)*

Yet another contradiction is revealed between the 'support' and the reality. While the claim is that everyone in the national office wants to increase primary birthing due to its cost-effectiveness and better outcomes, there has never been clear action or policy ensuring accessibility or support for practitioners that offer primary birthing. *"If your midwife always goes into hospital that doesn't really give choice, doesn't give an option of primary birthing"* (Anonymised). Again, midwives are criticised for attending births in hospital, implying that this restricts choice, while failing to acknowledge systemic barriers such as hospital dominance and lack of structural support for primary birthing.

*There are no accountability measures. So, this is something that we're currently looking at, where are our accountability measures? We have to change hearts and minds, not just of midwives but of the birthing population. (Anonymised)*

These statements are contradictory in that they claim that 'hearts and minds' must change both among midwives and the birthing population, rather than recognising the Ministry's contributions to these systemic issues. This reinforces what Sian (section 8.3) identified as the Ministry's contention that, "*the more hands-off it could be the better*", as if these core issues can be fixed by an individual midwife.

*We're going to have a natural increase in primary birthing... we're starting to think about how we address the root cause of some of this stuff, and it is accountability measures. (Anonymised)*

The opinion at the Ministry was that there will be a natural increase in primary birthing resulting from imposing accountability measures on midwives. As the dialogue continues, workforce shortages are acknowledged. "*At the moment more and more and more and more and more whānau cannot get a midwife as a Lead Maternity Carer and that's why they're in the community team, and then they don't have an option of home birth*" (Anonymised).

Karen had identified this issue (section 7.5), reflecting that hospitals are not set up as Lead Maternity Carers for consumers requiring complex care. Therefore, as hospitals fail in supporting midwives to offer primary birth options, midwives become inundated with complex pregnancies. Ironically, now that consumers are having difficulty finding a midwife, hospital teams are offering home birth services.

*We have a lot of districts now enabling home birth to happen when their women are under the community team which is a huge step. Absolutely massive step, to allow people primary birthing and home birthing for those women, because those women for 20 years did not have choice. So, this whole idea of choice in this country is a fallacy, there's choice for certain people. (Anonymised)*

The claim that only certain people have choice and only some have access to a home birth is what the Act intended to change, for all women. The Ministry's rhetoric around promoting normal birth stands in stark contrast to its actions, as it has consistently failed to prioritise funding and structural support for the midwifery profession. The

Ministry has not shown any accountability, while the broader attitudes towards midwives within the Ministry have remained dismissive and unsupportive, further undermining midwives who promote primary birth, a model that the Ministry claims to endorse.

*What happened in the 80s happened because of the environment they were existing in, and they were forging through, but they did set it up in a patriarchal system. And one of the things that happened is we became the protectors of women. We never needed to protect women... Women can absolutely protect themselves and their whānau can protect them. And we demean them by protecting them. And what's happened is, we've had this ideology that we are the protectors of women. It's written through loads of stuff, 'We protect. We protect. We protect', them from the big bad meanie medical service. We protect them from GPs, we protect them from everything. (Anonymised)*

There is acknowledgement that midwifery was established within a patriarchal structure; yet midwives are then criticised for positioning themselves as protectors of women within that patriarchal structure. On one hand, the Ministry recognised that midwives in the 1980s were forging through an environment shaped by male-dominated medical authority, which necessitated a shift towards autonomy and a partnership model of care. On the other hand, the Ministry dismissed the need for midwives to protect women, implying that such protection is unnecessary and demeaning. This position does not recognise historical and ongoing power imbalances within maternity services, where medical dominance has undermined women's agency in childbirth. Furthermore, while they are critical of midwives for shielding women from medical overreach, the Ministry fails to acknowledge that the very establishment of midwifery-led service was in response to the medicalisation of birth, which systematically disempowered women. What is most apparent is the absolute silence in recognition around their own contribution to the reasons midwives have developed coping mechanisms in order to remain working in their profession.

### 8.3.2 Deceitful Othering: The Ministry Fails to Pay

*There's a built-up resentment over many years of being overworked and underpaid when they know the value. And it's all very well, being overlooked and underpaid when you don't know what you're worth, but midwives, they know what they're worth. (Bronwen)*

The built-up resentment Bronwen touches on above is regarding the Ministry's failure to adhere to equal pay for midwives from 1993, as outlined by the legislation. This section sets out to demonstrate the processes by which the Ministry of Health had been deceitful in their negotiations with the College of Midwives around increasing funding for independent midwives. The Ministry's othering of midwives is exemplified by its repeated failure to honour funding contracts and its neglect in fostering a professional relationship with the College of Midwives.

In instances where the medical fraternity had argued that patient safety is their chief concern (Gendall, 2001), there has been no support from the Ministry. Susan shares an example from a Perinatal and Maternal Mortality Review Committee (PMMRC) meeting, where the committee had statistical evidence showing the benefits of primary health services in reducing inequities and offering the best outcomes; yet, they still decided to close a primary unit which was offering the best outcomes.

*At one of the PMMRC meetings, they said, 'What we're needing is more continuity of care particularly for low decile women'. And at the same meeting they said, 'And we're closing the last (primary health unit)'. At exactly the same meeting. (Susan)*

Despite the service following its own evidence, which identified better outcomes for mothers and babies than the hospital, hospital management closed the primary unit which provided the best outcomes. This decision was made to prioritise funding for the hospital which favoured medicalised treatments, with known evidence of poorer outcomes. Hospitals, as recipients of Ministry funding, have the authority to close primary units. This raises significant ethical concerns, particularly as the Ministry has not intervened to address the health inequities perpetuated by the hospital model. Instead, the more costly institutional model has been prioritised, thereby reducing available funding to fully compensate independent midwives.

As the funding conversations continue, with minimal progress, the impacts are noticeable within the workforce and in midwifery education. Christine describes the ongoing impact on the profession and the onus on midwifery educators to inspire optimism in budding midwives.

*The Ministry has reneged on our pay and we're still waiting, years later, because still, nothing's happened. It's still nothing, nothing,*

*nothing, and we say to the students, 'It's a great time to be a midwife, by the time you get through it'll all be sorted'. And we've been saying that for 14 years, and it's still not sorted. (Christine)*

The chronic lack of recognition for midwives has had implications on sustaining the workforce. Since its inception in 1989, the College has worked in support of its membership to negotiate for better pay and working conditions with the Ministry.

*I mean the other thing that is really frustrating is the Section 88 contract model is very dated. It's from the 1990s and it's stayed the same. It's very unusual to have a central funder individually contracting each individual practitioner. And we thought we'd got that over line when we went to court and got the co-design, when we proposed this new model. It was all beautiful and then they just completely disregarded it. (Alison)*

The College lodged a pay discrimination lawsuit (Bateson, 2015). This resulted in the High Court judge ordered the Ministry to engage in a collaborative process of 'co-design' to develop a new funding structure and better working conditions for independent midwives. The Ministry tasked Bronwen and others to work alongside the College and over the 9-month court ordered process of renegotiating the funding structure with midwives (Guilliland & Pittam, 2017). The Ministry engaged in the redesign process but then, when it was completed and presented, the Minister dismissed the entire platform (Radio New Zealand, 2018) and payments to independent midwives were not increased (Devlin, 2019).

When the Minister of Health did inject a small amount of funding into the health system for midwives, it was allocated to hospitals as an incentive to encourage midwives back into hospital practice rather than to increase independent midwives' pay (MoH, 2021). This is another example where the Ministry, by refusing to negotiate with the College who speak for the collective of independent midwives, actively ignored midwives as a profession. Individual midwives have no ability to negotiate changes within the Section 88 contract. The strategy the Ministry is employing, is one that the hospitals used in 1990 when independent midwives attempted to gain access to the hospitals.

*The Ministry has settled for just working with the system that they've got to try and make it palatable. And it'll never, it'll never actually compensate midwives properly because it was not set up properly in*

*the first place. Based on what the value of the work actually is.*  
(Bronwen)

Bronwen outlines the Ministry's unwillingness to acknowledge the profession's value. The Ministry has maintained an antiquated system with the full awareness that midwives are systematically underpaid, unsupported, and overburdened. At the same time, they perpetuate a structure which favours medicalised maternity care.

Individually, midwives have little recourse, apart from taking the MoH to court, which is a lengthy and expensive process with no guarantees that the Ministry will comply if the decision sides in their favour. The Ministry could simply appeal.

The continued use of an outdated contract is more beneficial for the Ministry than for midwives. The Ministry has failed to appropriately resource the profession. The continued strain on the workforce leaves midwives in dangerous situations from overwork (Young, 2015). The evidence suggests that poor maternal outcomes derive from midwives who are overworked and under-resourced, especially in the more rural areas (Crowther, Smythe, & Spence, 2018).

Bronwen illustrates the impact of the Ministry's actions on her sense of professional worth and personal well-being. The Ministry's persistent failure to improve working conditions for midwives has devalued their contributions and placed significant strain on the whole profession.

*When I look back, by the time I got to the end of that process of the co-design and having that so fully rejected and then myself side-lined within the work, I think by then I was done. I was pretty rung out and while I hung in there for maybe 18 months or 2-years, by that time I was pretty ragged, and I needed a lot of recovery time to get over that. As more and more things have sort of dawned on me. I don't come out of it with any real regrets, my regret is around the Ministry's behaviour, really. They were very dishonourable in their functioning, and I still feel really sad about that. I think they really didn't go into the negotiations and the settlement agreement with good faith.* (Bronwen)

Those involved in designing a new fee structure expressed feelings of disillusionment and that the Minister had no intention of making improvements for midwives.

*The mediated agreements that the Ministry then broke twice, not once, twice. We did all that work on it and then it was just completely rejected. Not even one recommendation. It was just rejected. It was like no, they're not doing any of it. I don't think it was actually properly considered. They just looked at the amount that the co-design work came up with and, 'That's far too much money for that person to be earning, so we can't be doing that'. The unfortunate thing was they didn't then go, 'Hang on a minute, what might be a first step?' Because one of the first four things that we could do wouldn't necessarily affect the money side of things but would actually make the working conditions better. They didn't do any of that, which was just appalling. (Bronwen)*

Bronwen suggests that the Ministry vetoed the advice on the grounds that independent midwives would earn too much. While the financials may have been a minor factor, the fact that the Ministry rejected implementing any of the zero-cost strategies identifies bad faith beyond mere budgetary concern. Their unwillingness to prioritise the workforce identified a dereliction of duty on their part.

*I was aware that within the Ministry there was a tension about midwives, now when the first pay equity they had that long 9-month process of negotiation with the Ministry. Then when they went to the Minister, they'd come up with a whole proposal and the Ministry said, 'We don't agree with it'. And the College was completely surprised by that, but with an election coming up I think that they were never going to approve. They just went along with a process. (Sian)*

As Sian shares her perspective around why the Ministry simply “went along with a process” her ideas thread into broader notions of power and control. She identifies that while midwives are considered essential for safe childbirth, the Ministry is unwilling to recognise the financial reimbursement required. This unwillingness affects the social opinions and worth of midwives’ by reinforcing patterns of gendered economic oppression more broadly.

*I don't think it was actually properly considered. I think they just went, 'That much money?' And I think there was a visceral reaction to the idea of women earning that amount of money for the work they did. So, it really brought home to me that whole thing, 'women and babies. Women and babies'. But actually, what we mean is, 'babies'. It's not really women, we're not really that interested in women. We're only interested in babies coming out good... So, I've just put it down to being deep seated institutionalised misogyny. That [notion] 'It can't possibly be worth this amount of money'. And yet all the lip service to the beginning of life... There's nothing intrinsic in our*

*society that says, 'We must look after you'. And there's nothing structural in our society that says, 'We need to take care of you because you're producing the next generation, so you don't need to work so hard. We're going to fund you for this, that, and the next thing'. It's just, 'You're on your own, mate'. (Bronwen)*

The distinction made here between 'babies' versus 'women and babies' reflect beliefs that women are merely vessels for reproduction, rather than individuals deserving of support. Expanding on that idea, if the Ministry considers women as mere vessels, then there is nothing to negotiate with; thereby justifying the structural neglect midwives experience when advocating for their profession.

Midwives have been labelled as untrustworthy rather than being recognised as specialists in primary maternity services, which highlights the level of othering the profession has been subjected to by the MoH, the central funding body. Furthermore, the individuals who aligned themselves with or advocated for midwives were also rejected, side-lined, and disregarded. Towards the end of working at the Ministry, and after years of being exposed to the type of ill treatment that goes along with othering, Bronwen quietly retired at the onset of the COVID-19 lockdowns in 2019. Her work had always been focused on creating an empowering birth experience for women and creating a safe environment for midwives to practice.

Alison and Violet discuss the Ministry's decision to prioritise funding for GP services during the pandemic, rather than allocating community funding where the virus was circulating. Midwives continued to visit babies beyond the 6-weeks and post-natal women who were outside what they can claim payments for. While GPs were given funding from the Ministry, although at that time they were not seeing patients, midwives were not compensated for their work.

*Pegasus being paid \$10 million out of COVID money that they didn't actually use. They got paid and it's gone into their bottom line, and they didn't do the work. We have midwives doing triaging, referring, recognising illness, meeting other needs, continuing to visit past 6-weeks because they knew that family, that baby needed to be weighed, and the Well Child service were saying, 'No we can't do that. You just need to keep visiting'. (Alison)*

Violet adds to Alison's statement.

*During COVID, midwives were in many cases the only health professional seeing whānau. They were not going to see the GP and you weren't getting face to face time with the GP, if they did get an appointment which was very hard. They often had to sit in their car in the carpark. And then Well Child services withdrew completely.*  
(Violet)

Karen outlines the commitment of midwives to act as frontline practitioners in an earlier tragedy. In 2010, Christchurch sustained a series of massive earthquakes. Karen reflects, *"in the earthquakes, the only group of health professionals that could have access to their notes and knew what was going on for these women were the LMC midwives because they carry their notes"*. This was because the College set up the maternity services as women-centred, pregnant people always retain their own clinical notes.

Despite historical evidence before the Act in 1990 that midwives show up, Bronwen was retaliated against rather than being positively acknowledged for her duty of care to attend birth at a time when the GP would not. In 2010 midwives carried on during the earthquakes, and in 2019, during an extended COVID lockdown period, yet again the illtreated, forgotten, and unpaid practitioners were midwives. The Ministry has clearly demonstrated through their funding practices that they prioritise the medical model, and that their interests do not align with midwives, women or their babies.

#### 8.4 Hospital Institutions' Othering of Independent Midwives

As discussed in the previous section, the Ministry has largely refused to meaningfully engage with the College of Midwives since 1990; furthermore it has disregarded the advice of their employed midwife advisors. In doing so, the Ministry has set a precedent which influences the broader health system. Hospital institutions value uniform behaviour, adherence to standard procedures and protocols, and there has never been any real incentive for large hospital institutions to act collegially with midwives working in the community. Bronwen elaborates that despite some individuals having strong relationships, at the institutional level, midwives overall were not embraced.

*All the antagonism between the hospital system and the community-based systems, some things were always really difficult. The interface was always really difficult, and it didn't need to be, but it seemed like*

*the people in charge of the hospital system weren't able to fully embrace the change. It always seemed that the community-based midwives were 'other', like they did things differently; and while individuals had really good relationships, I don't think that the hospital system overall embraced the new group, even though they'd tolerated GPs doing maternity for years and years and years. It was almost like, 'What are midwives doing in the community?' They weren't really part of the system. This system didn't embrace them and say, 'You are part of our system'. It was like, 'You're different. You're doing other things'. (Bronwen)*

Bronwen's perspective stems from her expansive career, spanning more than 3-decades as a core hospital midwife in the 1970s, a domiciliary midwife, hospital charge midwife, advisor within the College and the Ministry. Her insights into the complexities of the professional relationships began prior to the Act until she retired from service in 2019.

Bronwen identifies how, due to lack of clear funding and guidelines, hospital midwives are not always able to identify where the professional boundaries lie between themselves and independent midwives.

*I think a lot of what I found when I went into a maternity unit was as a group of midwives in there who were employed for a long time, [they] had a particular mindset around doing what they were told. Particularly in one hospital that was so strongly obstetrically led, 'Well, we do things this way'. And they weren't quite sure if a client of a self-employed midwife [came in], it was like, 'Do I treat you any differently or do I let the midwife do everything?' And that's ironed out over time, but I think underpinning it all is the lack of recognition through payment, in both places. The hospital systems have not encouraged their midwives to take on the full role because that gets very messy, and actually in an employment situation, you want people who will do what they're supposed to do, just do what they're told, really. (Bronwen)*

As participants mentioned, the attitude surrounding the profession held midwives as 'untrustworthy'; an attitude that prevented the Ministry and some hospital institutions from engaging with the College. The College has repeatedly requested structural support around the profession which has yet to be recognised, implemented, or acknowledged. Further, the Ministry has not provided delineations between the health services to limit hospitals over-delivery of services to primary health patients. In most cases when an individual presents in the hospital for treatment, when a hospital

cannot recoup payment for that treatment or service, the individual is not admitted and advised to contact their primary health provider. Paediatricians in the hospital or in private clinics do not attend to infants or children that present with primary health signs or symptoms. The patients of paediatricians are children who are referred to them by a primary health practitioner for specialist consultation or treatment.

However, in pregnancy-related concerns, the hospitals, obstetricians, and the Ministry have not clearly defined the primary health and specialist requirements. Even in the mid-1990s, consumer reports expressed concerns with medical hierarchies of power within hospitals and private obstetricians that used the hospital for their own gain (Women's Health Watch, 1995).

Despite the passage of time, Karen describes that the same bad faith and antagonisms occur. The notion of the 'untrustworthy' midwife is alive within the hospital and Ministry institutions, as colleagues reinforce the behaviour and justify their actions.

*It's the same today and it's slowly killing us. Most hospitals wouldn't do their part of the bargain, of an integrated community and hospital service using the best educated health professional for the woman and baby's needs. (Karen)*

The Act 1990 legislated midwives' access to the hospital; however, most hospitals did not create the structure required to support independent midwives who most frequently use the service. Instead, many hospitals overstep their clinical boundaries by providing primary health services to maternity patients who do not meet the threshold for tertiary services. When hospitals prioritise primary health, they often utilise resources which should be left for patients with tertiary medical needs.

Alison outlines an example of when hospitals exceed their intended role in maternity care, service needs become blurred, leading to blame, confusion, and inefficiencies. Conversely, when hospital staff fail to fulfil their designated responsibilities, critical gaps emerge and, in this case, leave an independent midwife in the community without the necessary support from the tertiary hospital, when medical assistance is urgently required.

*We had a phone call from a midwife. A woman had a baby and she [the midwife] visited her at home. The woman started to get sepsis, the woman was unwell, the midwife called an ambulance and took*

*the woman and the baby to the hospital. The woman had had a baby that had died the previous year, and she was really distrustful of the hospital system. She didn't even want to go to the hospital. So, when everyone was out of the room, she discharged herself and took herself home. The midwife went to see her the next day. The woman was sicker, really sick, septic, really low blood pressure, terrible, rang the hospital and they said, 'Well you'll just have to bring her in. There's nothing we can do to help you. You'll just have to bring her in'. So, she rang us and luckily our advisors managed to get through to the midwifery lead at the hospital who got an outreach team to go and visit the woman at home. So, if that midwife hadn't, that's a near miss, that woman would have died, and the hospital's response was completely inadequate and here you've got this lone individual midwife trying to fix this problem. (Alison)*

Within the New Zealand maternity system, individuals can choose to undergo clinical treatments that are not medically indicated if their provider recommends a procedure. This flexibility, however, contrasts sharply with cases where hospitals fail to fulfil their responsibilities, as seen in the situation above. While hospitals often blur service boundaries by providing care to those who do not meet clinical criteria, this instance highlights a clear failure to deliver necessary care rather than the more common tendency to over-provide, as indicated with clinically unnecessary caesarean sections (Douché & Carryer, 2011; McAra-Couper, Jones, & Smythe, 2012). Bronwen identifies the process of how the hospital system perpetuates the medicalisation of birth by allowing practitioners to perform clinical treatments in the absence of medical need.

*It just seems that everybody's powerless to do anything. Nobody will stand up to the doctors. I mean, that's really what it boils down to, from my point of view. Is saying, 'no, you can't do that here'. So, nobody will say that because you know, they're doctors, and their clinical decision goes, even if it's wrong. And we keep quoting, 'the government doesn't fund elective caesarean sections for no clinical reason'. But then you see, if you're an obstetrician, you just find a 'clinical' reason and their clinical reason might be, 'terrified of birth'... In their head it's a psychological reason why you can't actually birth a baby. And the fact that they do absolutely nothing... to get the woman who is frightened of birth to not be frightened of birth is neither here nor there. (Bronwen)*

Jackie discusses how fear of birth has the potential to negatively affect labour and birth. She outlines that this fear has almost been eliminated with the implementation of the midwifery-model.

*It doesn't have to be as bad as it sometimes is because women are frightened of pain. These days they're frightened of birth again. They went through a phase, I said to Liz the other day, we have the best of it because women became un-frightened of childbirth and so that was really wonderful, because the pain is not so bad. Fear makes the pain much worse. Anxiety makes the pain much worse and look how frightened and anxious our younger population is today. So that alone will affect physiology, and if you don't understand about the effect calmness, quiet, confident processes, good communication, understanding that all of those things with the encouragement and support in a gentle and encouraging way, will activate the endorphins needed for the labour and birth or breastfeeding to happen naturally. And so, you have women who have an experience that is much more painful than it might otherwise be. (Jackie)*

These examples highlight the differing perspectives in the medical and midwifery models. While traditionally midwifery supports women through their fear and/or their pain as a normal progression of in labour, the medical model is akin to the knight in shining armour, stepping in to 'rescue' the birthing woman by taking the pain away. The subtext is clear, 'you can't handle it'. The presumption is not based on a woman's actual experience or expressed need, but on a predefined belief that she will be unable to manage. Rather than empowering women, the system pre-empts their perceived inability to cope and places medication as the default solution. Ironically, childbirth is one of the few areas in women's health where pain is arguably pharmaceutically over-medicated; and, notably, where women are not required to ask for relief (Leap, 2000).

Conversations about pain management begin in late pregnancy, far before labour has begun, and sometimes before any labour pain has been experienced. This raises an important question: how can someone anticipate what their pain management needs will be in a situation they have yet to experience? The pre-emptive framing of these discussions reflects a deeply paternalistic assumption that women will not, or cannot, cope with labour pain. The metanarrative that labour is so painful—'we don't believe you can handle it, you can't manage, therefore we need to medicate you, let's plan ahead because you're not capable'. There is no space within the medical model, with rigid timelines like the 2-hour rule (section 7.1) and prescriptive notions of how long labour should last, for truly supporting women through their birth process. These time-bound frameworks, which date back to the 1940s, leave little room for individualised treatment which labouring women require.

*The local maternity unit in Waiuku... she remembered this little primip she was so afraid, just so afraid, 'I just took her fear into me and in 15 minutes her labour was just going okay'. Now that is good midwifery in my book. You take people's fear into you. You help them to release it so it's not there, so that your body can do what it needs to do... Mavis Kirkham was at Sheffield University for quite a long time... I remember her telling a story about an old homebirth midwife in Britain, the village midwife. She would go to the woman's home, and she would just sit with the woman, and she'd be knitting. Everybody knew that if the knitting stopped you got worried, yeah so that says it all in my book, it really does. (Jackie)*

This presumption of pain is unique to childbirth. In labour, the assumption is inverted, pain is pathologised in advance, and the medical response is to intervene proactively—not because the woman has asked, but because the system has already decided she will not cope. The hospital, in deflecting responsibility back onto the midwife, instead of collaborating, reflects a systemic failure and highlights the disparity between support for midwives in the community compared to institutional midwives. This systematic marginalisation undermines midwifery and contributes to a reliance on a more costly, intervention-heavy medical model. One that, perhaps, disproportionately affects women at greater risk, ultimately benefiting doctors at their expense.

Below, Sian indicates the financial ramifications that the Ministry has not dealt with, when boundaries between primary and secondary practitioners within hospital institutions are not clearly delineated. While the examples show hospitals have expectations that midwives should address community patient needs independently, they simultaneously support doctors to access funding from multiple sources. While the Ministry refuses to honour pay equity for midwives, they allow doctors to be paid several times over for the same patient.

Although private obstetrician practices are not abundant in all areas of New Zealand, they do cluster around affluent areas and work within the public hospital. Midwives are not legally able to collect fees from patients, although obstetricians have a unique financial arrangement, which is reinforced by hospitals and the Ministry.

*There is an issue of triple dipping. The obstetrician is being paid directly by the woman, being paid by the [hospital], and then claiming off the notice. So, if you're an obstetrician who works 9/10 in private practice but 1/10 in the [hospital], the day at the [hospital], one of your women comes in but you're going to charge her and claim off*

*the notice. And there's never been any appetite really to stop that happening, not at all. (Sian)*

Doctors collect payment three times for a single patient visit and treatment, while concurrently the Ministry refuses to negotiate a financial increase with the College for independent midwives. So long as the hospital directors view midwives as 'other', the relationship with the community practitioner is devalued. At the same time, hospitals prioritise more affluent patients who choose to afford and fund their preferred treatment. While it is acceptable for patients to privately fund their chosen healthcare practitioner and treatments, the Ministry and hospitals have created an ethically complex situation by allowing obstetricians to utilise the public hospital resources while also preferencing private patients. For instance, an elective caesarean section requested by a private client, is performed in the public hospital and funded by taxpayers' dollars. The NZ\$8,000 a patient will pay to an obstetrician to avoid the public health system is only for their private obstetrician (Origins, 2025). This fee does not cover the treatments provided to a private patient while they are in the hospital—those are covered by the taxpayer. This practice raises questions about the equitable allocation of public resources and the prioritisation of services within a publicly funded healthcare framework.

*It actually makes a significant impact on the way that it gridlocks the system. It actually creates more inequality because the private obstetrician comes in and sees private patients and leaves the public patients in the corridor. (Alison)*

The hospital system prioritises obstetricians and private patients, when many of these patients do not medically qualify as requiring tertiary services. This indicates a neglect to delineate roles between secondary care practitioners working in a hospital setting. The metanarrative that midwives in the community are not provided additional support means they are expected by hospital staff to manage high risk situations independently, while hospitals prioritise funding doctors with funding from the Ministry's maternity budget. These funds could instead go toward independent midwives; thereby upholding the Ministry's negotiations with the College. As a specialist field, obstetrics is intended to focus on patients whose conditions meet the medical criteria for specialist care. The hospitals who have many private obstetricians could alleviate this issue by not allowing them to book private patients into their

hospital clinics, as one example. However, as Sian states, there has not been an “*appetite to change this behaviour*”.

#### 8.4.1 How Othering Controls Professional Autonomy

Bronwen outlines how one institution responded when the entrenched practices were challenged.

*I went and took on this new manager job and completely turned the place upside down. The obstetricians absolutely hated me with a deadly hate, because they ruled everything, and I was for women and for midwives. I just wanted to make it very easy, relaxed, open to families, women could do what they wanted, all that sort of thing. Anyway, it got me into a lot of trouble and eventually they put me on gardening leave, and they paid me some money to go away. Well, I negotiated a payment so that I would go away. It was awful. It was terrible. (Bronwen)*

Reportedly, that hospital reverted to the same obstetric-led culture even before Bronwen had been constructively dismissed and negotiated her payout. Rather than engaging with changes and creating a family friendly environment, the institution chose to scapegoat Bronwen. This highlights a priority to retain existing hierarchies, even when changes could benefit midwives and patients.

Later, when Bronwen worked in the Ministry, her values did not align with the Ministry’s priorities, and again this made her a target. The Ministry also made an example of her to everyone else, of what could happen when one is not in alignment with the culture of the dominant institution, be it the Ministry or the hospital.

Rosie, who is still practicing, shares a recent hospital experience. She highlights how midwives’ autonomy is monitored and controlled by hospital staff because of othering and when midwives do not behave as is expected. Although midwives have had the legal status to practice independently for the past 30-years, their clinical decisions are still questioned. Rosie discusses what it looks like when midwives are seen as not conforming to the rules, disguised as guidelines (section 9.1.1) and aligning practice to the approved medical model.

*Anytime I am in the hospital, which is not often, because I mostly work in home birth, there’s a sense of supervision over your practice. You can be in the birthing room but there’s a total awareness outside*

*of that room of what's happening, how many centimetres... The hospital I work in, the charge midwives and/or obstetricians have been known to sneak into the supply cupboard and listen through the door to know what's happening in that room. When you're the midwife in that room, there's a real power dynamic and you're held to account. You come out of that room to have a break or go to the toilet or update the team, and the, 'What's happening in there? What are you going to do next?' And 'when are you going to do this xx intervention?' There's a real sense of trying to manage your practice and the implication is that when you're doing those things, 'if you don't agree with what we're saying, we're going to be going to be judging you for that', and sometimes that takes the form of a complaint through the internal hospital processes or a report to Midwifery Council. (Rosie)*

This example of surveillance is an attempt to correct behaviour, corral independent midwives' practice which therefore minimises professional autonomy. The threat of a complaint from the hospital staff, contributes to an unreasonable power dynamic to interfere with midwives' clinical decisions by the hospital staff. Through the supply cupboard, a midwife's autonomy is questioned and challenged in a process of surveillance. If the hospital staff were acting collegially, they could simply support the independent midwife by asking her if there is anything they can assist her with, as Carolyn exemplifies in section 10.1. Carolyn outlines the shift in hospital expectations of midwives' practice and the contradictory practice behaviours between the medical versus traditional home birth model.

*As you get caught up in more and more and more red tape and often all the documentation, it's like an encyclopaedia now, a lot of that is covering your back really. And so that you're busy doing all these notes and now they've got computer setups, so you're busy working on that. You could just be with the woman. It's interesting looking at my old notes, yes the partogram, that was definitely kept up but the actual written notes, there might be a couple of hours in between before you made a note. But now it's like every 5 minutes even if it's just to say, 'observations all normal, coping well' or whatever. All that documentation distracts you and takes you away from actually being with women. (Carolyn)*

The participants identified how their professional practice comes under hospital employees' scrutiny. This is another example of othering which impacts midwives' clinical decisions and behaviour and, therefore, their professional autonomy.

## 8.5 Conclusion

This chapter explored midwife participants' narratives of systemic 'othering', starting from the Nurses Amendment Act in 1990 and continuing until 2023, when data collection for this study ended. As discussed in Chapter 6, 'The Early Years', systematic othering of domiciliary midwives was apparent prior to the 1990 Act, manifesting subtly through snide remarks directed at midwives and to women when transferring in from home births. Over time, as midwives obtained autonomy, incidences of hostility became more pronounced, with institutions actively restricting midwives' access to hospitals (Guilliland, 1997). As participants mentioned, financial marginalisation by the Ministry has been investigated and it has been found to be withholding adequate reimbursement. This action further undermines midwives professional standing. Participants highlighted the lack of institutional support from hospitals and central government which, at times, contributed to unprofessional treatment from some doctors and even fellow midwives.

This chapter has outlined the metanarrative othering, showing that these midwives individually and collectively have been vilified throughout these years; although, to be clear, they are not victims. The metanarratives identified in this chapter include: the medical community arguing that midwives cannot be trusted and claiming safety as a reason to discredit midwives and undermine their autonomy. However, the ulterior motive was financial control over maternity service payments which links back to the narrative category othering of independent midwives.

The research question answered in this chapter was: How did the formal professionalisation of midwifery impact the financial sustainability and autonomy of independent midwives following the passing of the Act? The large institutions should have embraced independent midwives, as they are the largest group of practitioners who bring birth into the hospital and experts in primary health services; instead, they are 'othered'. Participants' experiences highlight the systemic biases held by those working within the dominant medical institutions in New Zealand.

The othering of midwives has disproportionately favoured doctors financially, allowing them to receive remuneration three times for the same patient. As many uncomplicated births take place in institutions, it represents a significantly higher cost

to the healthcare system (Dahlen, Drandic, Shah, & Cadee, 2022). Concurrently, midwives are confronted with surveillance which minimises their autonomy and limits a birthing person's informed choice. This chapter has illustrated how participants' experiences expose the power struggles embedded in maternity services, where midwife autonomy was resisted not for safety, but to preserve medical and financial monopoly and dominance. In recounting how midwives were vilified, the chapter has illuminated the persistent cultural metanarrative that undermines women's capabilities in birth, reinforcing the authority of the medical model. The next chapter presents how chronic othering has impacted the entire midwifery profession.

## Chapter 9 Findings: Narrative Category – Modern Maternity, ‘Med-ernity’

*It's a woman's profession in a man's world, that's the other thing. So you've got to be twice as good. (Bronwen)*

This chapter focuses on the narrative category, ‘modern maternity, med-ernity’, and speaks to the result of othering by the Ministry and the hospital system on the modern midwifery profession. The concept of med-ernity reflects participants’ ideas that practitioners within the maternity system have aligned with the medical model because of financial withholding, practice surveillance, and threats of reputational damage all resulting from othering. Practitioners are acting more defensively to remain safe against the threat of a tarnished reputation, public humiliation, or an inquiry (Dahlen, Drandic, Shah, & Cadee, 2022). Participants outlined that over time there has been an increased reliance on technology which minimises the confidence and skills of midwives, constraining the whole profession and restricting professional autonomy. Participants noted a shift of midwives conforming to the dominant medical model, midwifery practices becoming compliance-focused, and, therefore, technology dependent. Participant accounts identified that the current midwifery model is in distress. They discussed midwifery practice, education, and the Ministry, and outlined that the core principles on which the midwifery model was founded—partnership, choice (informed consent), empowering birth experiences, and continuity of care—have been severely compromised.

The metanarrative reveals that through othering the paternalistic structures have caused midwives to develop adaptive strategies to avoid standing out and ‘othering’. There is a consistent perceived threat of intangible elements which promote social pressure to conform practice, thereby minimising professional autonomy. Tangible elements, such as clinical evidence and statistics, which over years have identified safety of primary birthing (Renfrew et al., 2014), and traditional midwifery skills when used, serve as strong foundations to support physiological birth (Sriram, Almutairi, & Albadrani, 2024). However, within the paternalistic medical model, their value has been systematically diminished (Dahlen et al., 2022). Instead, the dominant medical model privileges intangible factors such as the implicit faith in technology, rigid

interpretations of timeframes for labour progression, and behavioural standardisation, for midwives and birthing women, through mechanisms of surveillance, othering, and the implicit threat of reputational harm (or being labelled a 'bad mother').

Midwives have adopted survival techniques allowing them to continue to practice within an environment that has not been supportive of them. This chapter explores these adaptive strategies and how some practitioners have modified their practice to remain in the workforce. The chapter sections are outlined in the story map grid which can be found in (Appendix E).

### 9.1 Defensive Practice Strategies

*'We'll just crucify her'. That's always been the case for LMCs. I think there are a lot of LMCs out there who just think, 'I'm out here on my own and this is a really tough job, I'm quite vulnerable, the way this woman is asking questions makes me feel unsafe and I'm going to carry 'the can' if anything happens. This woman doesn't really want the service that I offer, she's better cared for in a team where there are other people who can carry part of that load. It's disproportionate to what I get paid and there are other women knocking on my door. I'll take somebody who's a bit more aligned with what I'm offering'. And that might be more medical or might be more non-medical depending on the midwife. (Brenda)*

Brenda's account identifies a nuanced perspective of the level of responsibility midwives carry as 'disproportionate' to their financial reimbursement. An additional factor is the vulnerability of providing independent midwifery services, rather than a group practice to share the burden in, what might be considered by the midwife, a risky situation. A client asking questions about their pregnancy has been interpreted as making the midwife feel 'unsafe'. To further unpack this statement, the independent midwife, feeling vulnerable, deems herself unsafe to perform her role because a partnership has not been formed. The client holds the power because they retain the ability to lay a complaint, while the midwife practices under a potential threat of being 'crucified'.

Brenda identifies another factor which impacts partnership. The workforce shortage. Stating, "*there are other women knocking on my door*" suggests that for midwives to regain the balance of power, they are selective in who they 'accept' into their practice, which acts as a mechanism to self-protect.

Over the years, midwives have been exposed to criticism from their colleagues, clients, wider society, and institutions. Bronwen compares her generation of midwives that practiced in the early 1970s, to those practicing once the Act passed.

*Those of us who went out into home birth work, prior to the law changing, and even the ones who came initially out, we were pretty stropy old bags that had to stand up for ourselves and actually be staunch and all the rest of it. And I think the midwives who followed didn't have to be those things and so they got really hammered if something went to a coroner's court or the tribunal or whatever.*  
(Bronwen)

In Bronwen's account, the midwives practicing after the Act benefitted from the work of the participants. They had not lived through the trenches of getting the law passed, and they had not been exposed to the same level of open criticisms as the participants. Therefore, they were more vulnerable when criticised. What Bronwen does not identify is that the participants, in getting the law passed, had a very strong and close-knit community (country-wide) with home birth midwives and consumers. As Andrea (section 8.2.1) and Carolyn mention (section 9.1.2), many midwives who practiced later, did not have as strong collective support.

Participants discuss how for some midwives the vulnerability translated into practicing more defensively. Perhaps this was an attempt to minimise their exposure to confrontation and potential disciplinary actions by becoming less visible.

*But often for midwives, you're only as good as your last bad experience really, and if you're feeling vulnerable because you've had a bad experience where you've faced reprimand or censure then you will practice more defensively.* (Brenda)

Experience informs practice. When midwives are exposed to a supportive environment where they can safely debrief or have compassionate understanding after a bad experience, they are more likely to retain confidence (O'Driscoll, Allan, Liu, Corbett, & Serrant, 2018).

Jackie outlines how a negative experience can affect a midwife leading to a practice change. She highlights tensions between reality and the socially accepted perception that the use of technology will always equate to a good result.

*You can respond to an emergency but maybe not get a good outcome. It happens and it's very hard in modern society that thinks technology can fix everything, as a general sort of belief in our community, it is a faith almost. Some defensive practices crept in over the years for some practitioners and that's by no means universal and it's by no means hugely necessary but it's there, nonetheless. Even though you can't be sued, there's always a risk [of an investigation]. And even if the practitioner is found to be not at fault, that actually has on-going effects on a) on the practitioner's confidence, and b) practitioner's practice. People get frightened to have that practitioner, even though they've done nothing wrong and, in fact, they've probably done everything right. So, there's a risk to professional integrity and practice livelihood if they have a claim taken against them. It's not always easy to stay out of defensive practice when that happens. You could even have had a mate that it's happened to and then you're going to be more defensive too, especially until the outcome is known and I don't think there's a practitioner alive in maternity that hasn't had an incident of some sort, not necessarily with a bad outcome, but something that has given them real pause and a bit of a fright. (Jackie)*

Jackie identified the process whereby a midwife may impose defensive techniques into their own practice, often driven by the potential threat of investigation, even in the absence of fault. Even though the legal recourse to prosecute midwives is nearly absent, othering has damaged the profession to the extent that a negative experience can leave them feeling exposed and vulnerable. Socially, the community or media impose a type of extrajudicial justice in which individuals or communities determine and enforce consequence, a scarlet letter, if one will. A community's lack of trust in a particular practitioner affects their 'professional integrity and practice livelihood', creating an environment where the midwife is treated as a social pariah. She is avoided by the wider community, thereby affecting her practice. The same amount of energy used to persecute a midwife could be used instead to support them after a poor outcome if there was a social desire to support rather than assign blame and isolation.

The threat of these experiences has come to undermine confidence and tarnish reputations. As such, a widespread defensiveness has extended throughout the profession. Additionally, there is the issue of modern dependency on technology that Jackie described as a "faith". The use of technology seems to have become a protective mechanism rather than a piece of clinical information to base a whole picture upon, which is the mode of traditional midwifery. Joan Donley (1998a)

suggested that domiciliary midwives had an “enduring *faith* in the ability of a woman to give birth normally” (p. 18). The contrasting statements identify a profound shift in the brief 25 years between Joan’s and Jackie’s accounts, as the notion of faith has transitioned from the natural birthing process to a technological dependence.

The clinical justification supporting technology is an imaginary clinical presentation of ‘just in case’. Bronwen and Brenda suggest that medical treatments are imposed on women in the absence of a clinical indication.

*So here we’ve got this time-honoured natural process called, ‘having a baby’ which human females have been doing normally since ever there were human females. And yes, sometimes they get into trouble, and women die, a baby dies, and that happens all through the natural world as well, but why have we got this schizophrenic approach? And it is a schizophrenic approach, is that we medicalise it up the wazoo, but we don’t treat it as a medical event. We just say, ‘Well, it’s a normal thing; however, just in case...’. It’s terrible and the women just get caught up in all of that. (Bronwen)*

Brenda outlines the expectations from the woman’s perspective compared with what often happens.

*Women enter [the hospital] thinking that they’ll have a vaginal birth thinking that, ‘Help is at hand, just in case’, as they say, and they end up with a caesarean feeling like they’ve been hit by a truck, and for them, it’s sort of like, ‘How did that happen?’ (Brenda)*

Brenda highlights that within the hospital setting standard procedures, such as the routine application of intravenous lines or continuous cardiotocography (CTG) monitoring, are often implemented pre-emptively, under the rationale of ‘just in case’, despite the absence of clear medical indication or clinical need. The normalisation of precautionary interventions mystifies women who may not realise that the notion of ‘help is at hand, just in case’ often translates to the early onset of the cascade of interventions. This again moves focus from the woman onto the medical ‘rescue’, rather than offering assistance or support (Leap, 2000).

In contrast, Norma identifies a scenario when a woman is supported to labour and birth physiologically. She identifies what is required to combat legitimising medical interference.

*Well, you can still have your baby normally, even with a high-risk pregnancy in some situations and we see women doing that. Trusting your palpation, trusting your measurements, trusting the grow charts and not just, 'Oh, I'll just send her for a scan, just in case'. (Norma)*

Trust in one's clinical judgement takes time and experience to develop; however, once established, it becomes an integral part of practice. Bronwen identifies how faith in technology overrides the ability to trust in one's skill and the increasing oversight in autonomous independent midwives' practice.

*There's all the oversight now, like the constant ultrasound scanning. Behaving as if it knows absolutely everything there is to be known. And everybody knows that it's often wrong, but they still read it as if it's always right. (Bronwen)*

Bronwen identifies the relationship between technology reliance and oversight which determines midwives' practice. Despite technology providing incorrect evidence, the defensive practice is the standard of practice, using the incorrect information as the basis for a clinical decision.

*I think the reason we've landed where we are with high intervention rates in 2023 is because no one trusts women anymore. But we all trust the technology and think that will fix them. Unfortunately, it doesn't. (Norma)*

Bronwen and Norma both examine how the medical model is lauded as standard practice. However, the implications of technology-reliance dictating clinical decisions deteriorates midwives' autonomy, diminishes their skill and judgment and, ultimately, dilutes their trust in themselves and the birthing processes.

This term 'choice' was intentionally adopted by consumers as a tool for informed consent in teaching and research (Daellenbach & Thorpe, 2007). When adopted regarding 'choices in childbirth' as choice of practitioner and choice regarding the place for their labour and birth (De Vore, 1995; Christison, 2001; Clark, 1990; Guilliland, & Pairman, 2010; Strid, 1994). However, Karen identifies that when practitioners have not been exposed to physiological birth, they practice more defensively. When this happens, they are not upholding choice, as it was originally defined, indicating that the definition of choice has shifted over time.

*Unless midwives experience what you experience out in the community, they default to medicalised practice. They've gone back to active management of the third stage for all women, episiotomies have increased as have caesarean sections. Going into tertiary hospitals instead of using home or birthing units, some of this is women's choices but most is midwives' choice, I believe. (Karen)*

Brenda identifies how women's confidence and midwifery knowledge have been undermined by medical management.

*The Home Birth Association in Auckland was very successful in supporting the move to midwifery autonomy, with a view to making the home birth option more accessible and allowing midwives to work without medical supervision. But the number of women having the confidence to choose home birth has not increased, and midwifery practice is increasingly governed by medical protocols, and guidelines etc., instead of the instinctive 'with-woman' knowledge and practice. (Brenda)*

Brenda expressed that women did not take up the home birth option and described midwifery knowledge and practice with women as *instinctive*. However, the midwife participants identified that learning and unlearning develop confidence in birth (Chapter 6). Brenda also outlined how practice is increasingly governed by protocols and medicine as current trends, compared to "*with-woman knowledge*", the ancient wisdom surrounding childbirth.

Carolyn describes how practitioners present 'choice' in supporting their own preferences, a practice known as practitioner nudging (Cameron, 2020). She uses an example of speaking to one of her children, paralleling the underlying tone of a medical hierarchical approach.

*We all know that choice is a blanket cover really. A lot of midwives that came out of the hospital employment system and took up independent practice were driven by suddenly you could make a very lucrative living from it. And naturally that's a driving force in an economically biased culture and I completely understand that. But they were midwives who had only worked in the hospital setting. So, although home birth was seen as a viable choice, I mean I was really good at that with my kids, I'd say, 'You can wear that shitty old jersey if you want, for your school photo. You look hideous in it, but if that's what you want. Or you could wear this lovely new one that you actually look pretty cool in, but up to you. You want the hideous one or the cool one?' And I think that it was the same with the home birth*

*choice, 'Well, yes if you really wanted to you could birth at home. I don't do many home births and do have a few reservations about them because...'. And no woman sets out to put her baby at risk. So, there was that coercive and so even though it was woman's 'choice' it was a coercion to midwives' choice and obstetricians' choice. So that 'good women' and 'bad women', there are still elements of that afoot today. Often if you have a stroppy woman who says, 'No. Get stuffed. I'm not doing that' or 'I won't have that done', then the midwife is seen as, 'Well you didn't do a good job of educating her to our way of thinking'. There's still that sort of coercing going on. (Carolyn)*

Although the traditional medical hierarchy was historically upheld by 'med-wives', it continues to be reinforced through the enduring and reductive notion of the 'good' versus 'bad' woman. In practice, this dichotomy translates into 'compliant' versus 'non-compliant' patients, where a woman's assertiveness or refusal is perceived as a failure on the midwife's part to align her with the dominant medical perspective. However, Carolyn notes that when women do express personal agency, it exposes the midwives to institutional pressures, indicating that midwives have limits in their autonomy. Women and midwives who resist these control mechanisms, designed to compel compliance, are more often met with criticism than support, frequently confronted with the veiled 'just in case' threat, implying that a woman's informed choice endangers her baby's safety. This results in the medical model being prioritised over genuine respect for the woman's autonomy and informed consent.

Brenda outlines how nudging is used by practitioners to obtain their desired result. She identifies a common interpretation of choice and compliance.

*What most medical people think informed choice is, informed compliance. 'I'll tell you why'... It's, 'I'll recommend this, and I'll tell you why. And you will agree because, you know, 'I've explained to you what the benefits are'. (Brenda)*

Brenda outlines how practitioners present information with the expectation of obedience rather than 'consent'. Suzanne elaborates on reasons behind why there are midwives who have not adopted a faith in normal childbirth.

*It's the rhetoric of choice... We have a whole community who's not confident about birth, it's a wicked problem, isn't it? It's like it doesn't matter how much you educate and support, we have a community*

*narrative that birth is risky and dangerous and that's a very hard one to unravel. (Suzanne)*

Suzanne continues to describe how some practitioners use language to argue their own preferences when nudging.

*Over time when [midwives] make the transfer and the other model sweeps in; people lose confidence and less midwives seem willing to be really staunch about promoting birth in primary spaces. And so, if the midwives are saying, 'I don't want to go there because it's such a faff, if you have to transfer you might as well just be [at the hospital]'. That doesn't communicate confidence for families to choose that either. (Suzanne)*

Suzanne indicates that the medical model 'sweeps in' causing the midwife to lose confidence rather than a support of primary birthing within the mainstream medical model. Participants described how midwives' experiences inform their practice. Although Suzanne is referring to negative experiences, surely, support of primary birthing would bring a balance; if midwives were instead exposed to positive feedback when transferring into 'the other model'.

It has been argued that no matter how much one theoretically supports primary birth, the lack of support that midwives encounter perpetuates mistrust in primary birthing spaces (Ford, Crowther, & Waller, 2023). Therefore, midwives lose the confidence in primary birth, reinforcing the medical model. What is more, these accounts identify that practitioners are limiting available choices for families by deciding they do not offer primary birth options.

This section examined participants' reflections on the shift toward defensive practice, a strategy employed for self-protection in response to othering. The next section explores how this defensive approach, while serving as a mechanism for safeguarding practice and self, simultaneously leads to a standardisation of practice. This detrimentally impacts midwives' agency for themselves and their clients, limiting professional autonomy and informed choice.

### **9.1.1 Autonomy Constrained**

*It used to be that if you didn't give a uterotonic, for instance, it was your decision to make that call. Now it's that you've gone against the*

*guidelines. There are no longer guidelines, there are rules. And yet midwives have never been so well educated. (Karen)*

Due to the pressures of othering, more and more midwives are placing restrictions upon their own autonomy, employing defensive practice strategies, and becoming more medicalised in practice. As Karen outlines, guidelines were written by midwives to provide options for practice. However, rules are to be followed and when they are not there are consequences. Additionally, although Karen suggests that midwives have never been as educated, their education has shifted from using guidelines to following rules imposed by the medical model. As Carolyn expressed (section 7.1), before 1990, during her period of 'unlearning' hospital practices, *"there was a very strict rule, if women hadn't birthed their baby in 2-hours it was like an automatic forceps delivery"*.

This section presents factors that encouraged midwives to practice more defensively. They do not deviate from the written and unwritten 'rules' and do not challenge the practice in pursuit of self-protection. They want to fit in or, rather, not stand out to avoid being a target. In contrast, Bronwen described the domiciliary midwives as *"stropky old bags"* (section 9.1) which was necessary for these participants to challenge the system rather than submit to the status quo.

It could be argued that within the realm of professional autonomy one can dictate one's own parameters; for example, only offering labour and birthing options in a hospital versus a primary unit. However, to operate within the full scope of midwifery practice, a requirement to maintain New Zealand registration, practitioners need to *"demonstrate that they can practice the full scope"* (Pincombe et al., 2010, p. 243) which includes physiological birthing in the primary birth model.

However, Karen indicated that midwives now practice under rules, not guidelines, demonstrates the level of scrutiny midwives are under. Joan captures what this looks like in practice: *"so many expectations and so many forms to fill out and there's quite a lot of pressure in terms of performance. Writing your documentation properly and dotting all your i's and crossing your t's"*. (Joan)

Susan identifies how funding prioritisation impacts supporting practice, *"now clinical supervision is not supported so they don't actually spend a lot of time reflecting on today's experience or yesterday"*. Susan refers to a type of mentorship used to discuss

and reflect on their professional experiences. Clinical reflection is required for all midwives to maintain their registration, and it is the framework upon which their professional standards are based (Barlow, 2001; Pincombe et al., 2010). Susan identifies that students and newly graduated midwives are not supported to develop this clinical skill, despite it being fundamental to their professional development and maintaining registration to practice.

Bronwen compares her midwifery experience to midwives in practice.

*I've noticed over time that midwives have become much more task oriented. I asked myself for a long time, 'Why are these midwives over-working?' I just thought they overworked like nobody's business; they keep racing around doing things. My idea about being a midwife was being with that person and using all of your abilities and perceptions and skills to actually notice what was happening. And yes, of course you listened to the foetal heart; and yes, of course you did the odd examination or whatever. Although as my midwifery career went on I did less and less and less. Actually, because you sort of knew when everything was all going all right and you'd still keep your recordings up because you had to, because you had to document them. But other than that, rub her back here and there, put someone in the bath. There was hardly anything that you were doing and then the baby would come, and you usually catch the baby and then just stand back again. I just got used to the less, and less and less. Some midwives get into a reward system that the more and more and more things that you do the more rewarding it is. Whereas I was, 'no, it's best for me if I do less'. And then you could let it be the woman's experience. It wasn't my experience. My job was to ensure that things were going as they should and that everybody was well and healthy. That was my job, pretty much. (Bronwen)*

Bronwen identified that the practice of being has shifted to the practice of doing. An increase in practitioner tasks centres the practitioner and the medical model, not the woman (Leap, 2000). Through extensive experience in labour and birth, Bronwen honed her abilities, perceptions, and skills to assess the safety of a clinical situation without constantly 'doing'. She noted that her role in the birthing experience was to facilitate rather than engage in 'a reward system'. However, the difference is that Bronwen's practice always aligned with partnership between midwives and consumers.

Brenda outlines how women become locked into a set medicalised path when they thought they were simply engaging with an innocuous standard procedure.

*Women aren't educated before they become pregnant to know where the pitfalls lie. Like ultrasound scanning, for example, it's got a lot to answer for. It's nice to see that picture of your baby but as the technology gets more and more advanced, they can pick up anomalies that probably have always existed, but we just didn't know about and suddenly you find yourself in a risk category. Then it's really hard, unless you are particularly stroppy, and you've got a midwife that will support you to deviate from the 'recommended care for at risk mothers'. Basically, women have always been over a barrel with maternity because we want to retain our autonomy but we desperately want to do the best for our babies as well. So, there's always been that 'we can guarantee you a live baby', you know 'if you do as you're told' sort of thing. (Brenda)*

The faith in technology, coupled with midwives' adherence in following recommendations, or rather *the rules*, means that women and midwives both need to be staunch or stroppy in order to achieve informed choice and woman-centred care; as opposed to the current medical-technology-model which heavily relies on submission and the threats of the potential for 'just in case'.

This section identified how both women and midwives are constrained by a system that prioritises guidelines and technology over individual decisions and, therefore, minimises autonomy. Midwives are constrained by rigid rules and adherence to protocols. Similarly, women lack the support needed from their practitioners to mitigate pitfalls in maternity services, leaving them vulnerable to a system which prioritises compliance over choice.

While midwives are described as more educated than ever, their agency to act independently has diminished, reflecting a paradox where increased knowledge does not translate into autonomy. This has resulted in midwives being more vulnerable due to othering, while the increasing reliance on technology is seen as practicing 'safely', despite accounts from participants to the contrary.

### 9.1.2 Working the Model to Make It Work: Financial Implications of Othering

While Chapter 8 outlined how the Ministry has neglected to engage with the College to update the fee schedule for midwives, this section focuses on what participants described as strategies some midwives have adopted to maximise their income within the fixed funding structure. Although these strategies were mainly discussed by

participants who worked in Auckland, it may be indicative of behaviours across the country.

One tactic has been midwives increasing their caseload. Another strategy is to focus on one area of maternity services; for example, providing only postnatal services.

Although this does not support core tenets of the New Zealand midwifery system, such as partnership or continuity of care, midwives need to earn a living. Marjet has now retired from her role, however, at the time of our interview, she managed the process for independent midwives to obtain access agreement to Auckland Hospital. She had daily interactions over her 20 years in this role. She discusses her experiences, professionally and personally, around the shift in service delivery over time.

*A self-employed midwife calls in a backup because she's tired, which is great, but there's another self-employed midwife only doing back up. Earning a reasonable amount of money just doing back up. If we go back to, what did we want from the Nurses Amendment Act? I think this is not what we wanted, this is absolutely not what we wanted. We wanted self-employed midwives to be paid appropriately. Because they never got paid well. We wanted self-employed midwives to be available for women to do the birth and provide all the postnatal care. All that gets farmed out now and I use that word deliberately because there's another midwife that's just doing the postnatal care. Continuity does not exist for midwives anymore. And I noticed for my grandkids; I had to look hard to find a midwife who would provide full antenatal labour and good post national care. (Marjet)*

Despite having successfully passed the Nurses Amendment Act in 1990, the pay in 2025 continues to be an issue. However, now, instead of only domiciliary midwives struggling with finances all midwives are underpaid. Marjet indicated 'good postnatal care' and midwives receive a bulk payment for all postnatal services. The rate is higher if they visit fewer times which, effectively, increases the pay rate. Thus, at times midwives are condensing the services or offering fragmented services to recoup their financial loss.

*What we're seeing, unfortunately, is the fragmentation of continuity. We used to be 'an LMC' and that was what you did, your caseload was this big or that big, you can work this way or that way. Whereas now we're seeing, 'I'm just a postnatal midwife or I do...'. And the reason that can occur is because the workforce is so short. Historically women wouldn't choose that. They'd say, 'I want her because she's*

*going to look after me like this'. ...Whereas now, 'I just want a midwife now, I'll take whoever I can get. I just need a midwife so whatever she does, that's fine'. And that can happen because we've got this workforce issue that's enabling this kind of fragmentation to happen, sadly. (Alison)*

The points Alison touch on outline how, in just one generation after the Act, due to the stagnation of payments, independent midwives have created their own model for practice to maximise their pay. This strategy is a result of workforce shortages and women having fewer midwives to choose from. Carolyn outlines the implications of midwives increasing their caseload for pay.

*I think that midwives took on too many clients so that care became a lot more sketchy and you didn't have that same close relationship with the women. A hundred women on your books, you have to become time orientation and survival mode, to get through all that. There are probably things that came up in practice and you didn't have that, 'you're on the same side' situation. (Carolyn)*

To recognise the time commitment of 'a hundred women' equates to two births a week, associated postnatal visits, and an antenatal clinic. As Carolyn expressed, to perform this volume of work midwives become more focused on time and less time is available to develop quality relationships between the midwife and the woman. However, for midwives to work in the continuity of care model, the only way to earn a liveable wage is to increase their caseload. The 'sketchy' care, as Carolyn describes it, means that the professional friendship, the partnership, is compromised, compared to the time when domiciliary midwives practiced.

In addition to partnership suffering, Marjet identifies the workload of a large practice.

*I've seen midwives through my role in the access agreement, huge caseloads, huge caseloads, 100 a year, 120 and they're not doing the postnatal care. They're augmenting labour and doing induction of labour through an ARM or synto to bring the labour on fast and because it's all got to be timed, doesn't it? And often practicing the same ways as the private obstetricians, bringing the woman in at 7:00 o'clock in the morning, rupturing membranes put on the synto to make sure that we give birth by the end of the day. The private obstetricians could definitely do that because they are their own god, but self-employed midwives could bring them in and say, 'she's been niggling' or 'she's got this...' and just hasten it all rather than let the woman labour in her own time and that baby will come out in its own*

*time. They haven't got time, so they need to hasten it as fast as they can. It's completely changed, and the money is one of the things. So those midwives that have got high caseloads need more money.*  
(Marjet)

Carolyn and Marjet have outlined how midwives creatively manipulate the languishing funding structure to ensure they are adequately reimbursed for their service provision. While this supports midwives in making a living, it has negative implications on the woman-midwife relationship and the continuity of service.

Susan shares insight of how the lack of funding creates animosity between hospital midwives and those practicing independently.

*Midwives were having huge disagreements with the hospital midwives. At a meeting that they had together to see if they could find a way through, the LMCs were arguing a case which I couldn't believe. They were saying, 'I'm not going to go in there at the beginning of an induction. Why waste my time, my kids, my family is more important than my clients'. For God's sake, I was like [eyes-wide]. I couldn't identify with that. Whereas the hospital staff were saying, 'We haven't got enough people on the floor to do your early work. It's not my work, it's yours'. (Susan)*

Domiciliary midwives who 'showed up' for their clients no matter what, witness the next generation of midwives unwilling to practice in this way. Susan's account reveals how increasing medicalised practices create opposition. As primary practitioners, community midwives can provide secondary services or decide to hand over care to the hospital for treatment. Rather than breeding collegiality between independent midwives and hospital staff, the reliance on technology and medicalisation increases midwives' workloads while the payment structure has not been updated. Ultimately, this strains professional relationships, and it is the women who lose.

## 9.2 Modern Constraints in Midwifery Education

Thus far, the focus has been midwives practicing in the community to control their working conditions and pay. This section outlines the implications on the next generation of midwives—the students.

*The students don't see it. They see the midwives working giving fragmented care. Some midwives just do postnatal or just do antenatal or just do births. So, we're teaching the model of midwifery*

*as continuity and they're not seeing it in practice. And it's really hard as a midwife teaching because we know that continuity makes a difference, there's no doubt about that. And for a lot of us around my age, that's really soul destroying because we really believe in the model. And the women who really need continuity are the ones who just don't get it because midwives leave them once anything abnormal happens. Whereas we used to stay with them. A woman's journey is her journey, right? And you contract to be looking after her for their journey wherever it went. But now it's, 'Yes, I'll look after you while you're normal but as soon as you need an epidural or you know anything, I'm gonna leave you'. It's terrible, it's really hard. (Christine)*

Christine highlights how during clinical placements students are exposed to midwifery practice that reflects a fragmented model of care rather than the continuity of care that underpins the midwifery philosophy they are being taught. She identified this as 'soul destroying' because a major impetus in fighting for the Act was to provide the continuity model.

In the classroom, theory focuses on both physiological and complex maternity. However, in placements, students are not equally exposed to primary service. When midwifery students attend clinical placements they are often limited to within the medical institution. Andrea outlines the disconnect between theory and practice.

*The students say, 'I haven't seen a normal birth yet' and they're in their second year and haven't seen a physiological third stage. So, we talk about these things, but it's all just theory. All they're seeing is intervention for every single person just about, so we've sort of gone round full circle or even more than a circle, isn't it? Yeah, it got even worse than it was. Is it worse, is it worse? Yeah, I don't know. (Andrea)*

Andrea questions if maternity is worse than before 1990, echoing Marjet's statement "this is absolutely not what we wanted" (section 9.1.2) regarding what participants set out to achieve when changing the Act.

Jackie explains the difficulty of providing balanced placements of primary and tertiary services. She outlines the perspective that students, when exposed to the medical model, more readily adopt its techniques.

*There are just fewer midwives who are just available to supervise [students] because there's fewer in the community than in the hospitals. But the type of experience students get in the hospital is*

*different because in the hospital women are not midwives' clients. They've either referred from midwifery to obstetric service because they're complicated or they have chosen to have a specialist. So, the type of midwifery that is carried out is different to the totally autonomous decision making in the community. If you're a client of the obstetrician by choice or need, then the midwives are not autonomous completely, it's a sort of quasi autonomy, it's not quite the same. They're seeing more complex stuff, more technological stuff, more medical stuff and they have to absorb a lot of knowledge because they do need to be able to work in both settings. It tends to get prioritised in their minds because it's harder to learn and it's the technical stuff they really like. So, acquiring the epidural certificate and those things garner an importance that is greater than the things you can't see. (Jackie)*

As Jackie continues, she identifies that in one generation, practitioners' faith in technology is due to its visibility rather than developing a faith and trust in the woman and in her body.

*Somebody very clever, and thank goodness, did the research that showed just heat packs on the perineum ease that pain, and enabled the perineum to stretch and allow the baby to be delivered over an intact perineum. When I think about the midwives back in the 60s, they took pride in getting the baby over the perineum without a tear, and that was a badge of their skill and competence. (Jackie)*

Jackie suggests that students prioritise technological, medicalised practice in part due to obtaining a certificate; in this case, the medical procedure of epidural. Jackie's account identifies the importance students place on the tangible elements of their midwifery journey. Christine shares another example of tangible aspects of the medical model, for students, *"I haven't worn a uniform since 1989. I'm just astounded that part of the students' socialisation into midwifery, they really want to wear the scrubs because that makes them look like everybody else"*.

Both Christine and Jackie equate that for students their attire and obtaining certificates is part of belonging and fitting into the institution. Earlier in this chapter, Bronwen articulated that the midwives after the Act were not the 'stropy old bags' that the previous midwives were (section 9.1). The students attempt to assimilate and 'fit in'; however, this will not protect them from being exposed to the pervasive and widespread othering. Wearing a uniform to fit in and practicing in a uniform way does not provide the scope of experience that students require to practice in all settings,

such as primary units, as their clinical experience is weighted towards the medical model.

Jackie identifies the hazard of overcrowding student enrolments without an appropriately matched level of clinical placements.

*That mass producing of clinicians is not the answer because you cannot guarantee the wisdom of practice. Liz [Smythe] and I have worked together a long time, and she calls the 'know how' as opposed to 'knowing how'. You can't guarantee every midwife student is going to get that stuff, you can't mass produce them, if you start mass producing you get technicians. (Jackie)*

Jackie suggests that students (and practitioners) need to experience both settings for a holistic scope of practice. As the participants have indicated, there are many constraints on students obtaining both of primary and hospital experiences.

Brenda explains how midwives have conformed. While this may validate the midwife professionally, it compromises with the medical model which does not benefit the woman, the midwife, or babies.

*To actually succeed you have to conform and that's what's happening in midwifery. We've got women like yourself, doctors of midwifery. It hasn't changed a jolly thing, and I'm a little bit disconcerted by the apparent lack of acknowledgement of that. I see in midwifery forums, midwives talk about how wonderful it is now [that] we've got this many PhDs, and we're doing all this research. And I want to jump up and down and say, 'Look at the woman'. It hasn't, things are worse, if anything, for the women... There are some great women out there doing it. There are some fabulous midwives out there doing it as well, but I don't think the midwifery establishment is. They're playing the boy's game. Playing the technology game. Playing the 'letters-after-your-name' game. (Brenda)*

Brenda is critical of how midwifery has increasingly conformed to dominant medical structures and expectations rather than remaining grounded in traditional midwifery woman-centred autonomy. Success has become defined not by quality of care or advocacy for women, but by one's alignment with institutional norms. Brenda finishes by reiterating what has always remained important for the consumers: the woman, the person at the centre of midwifery service.

As fewer midwives remain in the workforce, women have fewer midwives to select from, and students have fewer midwives providing services that demonstrate the theory of primary care. Therefore, with independent midwives having modified their practice, women have little choice in how their care is delivered.

### 9.3 Partnership in Distress: The Millennial Mother

Participants reflected on the emergence of a generation of women becoming mothers who are increasingly reliant on technology, experience a diminished sense of community, and have evolving expectations of their midwives. Compared with the previous generations of maternity consumers who maintained a strong sense of self and partnership with their midwives, their daughters, who are now new mothers themselves, navigate their identities and relationships with practitioners in markedly different ways.

Over the course of the 30-years since the Act passed in 1990, midwives provide the predominant service for 94.9% of maternity (MoH, 2022). The focus of this section presents a shift in expectations of midwives by a new generation of mothers and birthing people.

*Women were being coached to have these high expectations of what their caregivers should be doing and shouldn't be doing. And without having any education that with choice comes responsibility for those choices that you make. Also, your midwife isn't actually the servant girl, she's someone who will walk alongside you, but she doesn't have to carry you every step of the way or jump when you say jump. So, it was like that whole relationship started to change and I don't know if that's actually been helpful for women. Because that element of fear has come into practice. We've got that, 'I'll breastfeed if I can'. So, the doubts have come back and that had actually disappeared. (Carolyn)*

Carolyn expresses the notion that some women have unrealistic expectations of what their service provider does. She also expressed that when putting the onus on the practitioner, rather than owning the responsibility as the consumer participants had, a lack of confidence and doubt seeps in. This undercurrent has been reintroduced in women and has affected the midwife-woman partnership.

Glenys shares her observations of this generation of women having their babies compared to women of her generation.

*I'm watching my daughter's friends; people turn up and they've got the baby stuff. They worry if they have the right clothes, and it's all about the baby. After the birth they come and coo and carry on about the baby. They don't fold that washing, they don't bring baking because there's no sense of community. (Glenys)*

Glenys mentions an absence of community. She notes that the focus has shifted from helping the woman with the practical aspects of mothercraft to a sole focus on the baby. The home birth community was very practical, bringing food for the family and, essentially alleviating some of the additional housework that comes along with having a new baby in the house. In addition, the home birth community had strong desires for an empowering birthing experience, and its absence amongst the current generation is palpable.

Bronwen observes that with the availability of information, through technology, women are bombarded with information. In order to connect, midwives need to provide individualised information.

*The majority of my midwifery care was about tuning women into their own experience and directing that experience to give them, ideas about what was possible, what they needed to worry about, what they didn't need to worry about. I think now the information that comes in at so many other levels, the midwife has to be really, really good at providing, easy, quick, good relating and education at that individual level. Some midwives aren't good at that, they're too clinically focused. They do the clinical things. I'm glad I'm not working as a midwife now. And when I hear myself and I listen to the midwives who are working, I think it's probably really good that I'm not out there because what I've got, I don't think would work in 2023, with the women as they are now. (Bronwen)*

Bronwen identified that if midwives are too focused on the clinical aspects of the visit, they may miss out on providing the information that a woman needs. She highlights that her skills of doing less and using technology with purpose, may not resonate with the contemporary woman and her expectations.

Brenda outlines that anxiety is more common now, generally in the public, affecting the birthing women and their families. Part of the midwife's job is to recognise what is the underlying cause of this anxiety to appropriately address the woman's concerns.

*A lot of women are incredibly anxious. And so you get the women who are asking lots of questions because they want to have their faith in normal childbirth, and you have to be really clear that you're not going to interfere. Then you've got the women who fear that you're going to make them have a normal birth [laughs] and so they're asking questions all the time because they're actually looking for and hoping that there will be something that comes up that means, 'I don't have to do this'. (Brenda)*

Both Brenda and Bronwen identify aspects of how midwifery and the relationships between midwives and women has evolved compared with a few generations ago. They highlight new challenges posed by women's varying attitudes toward childbirth and express how midwives are confronted with navigating these complexities within a system prioritising technology.

Carolyn shares a memory outlining the shift between the enthusiastic technology generation and her peers who used a technology-when-indicated approach.

*What was really sad was when the baby was born and the room went quiet, everyone was on their phones texting, 'the baby's here'. And there was a silence in the room. Then the mother would take a photo of the baby and say, 'oh look' [at the photo] and I'd say, 'I don't actually need to, I'm looking at the baby'. And the baby was kind of like, 'Where am I?' (Carolyn)*

Carolyn's degree of consternation relates to more than simply a generational shift. The use of personal technology reflects a wider cultural shift amongst both practitioners and families. Brownen explains how the dependency on technology and hospitals for childbirth equates to the increased use of technology when it is not clinically indicated. She identifies what will need to happen for a culture shift back to trusting the process of the human body and describes what has changed since she was practicing.

*Once you take it out of the community, it's lost very quickly. It's just lost really, really, quickly, people's connection. And so you end up with these great monolithic structures and everything's there. Everything that you could possibly need. Even if you don't need it, it's there. And if you don't need it, we'll give it to you anyway. It sets up a whole mindset. I just look around and I think that there's going to have to be another wave of the women's movement to actually get women back into their bodies and being more self-directed because we have lost it, man. We. Have. Lost. It. Through our phones and watching TV. I realised very early on that one of the attractions of ultrasound for people was it was like it's on TV. It's a connection to*

*TV... it's real, I can see it there... but actually, 'What's happening in my body? Oh, just ignore that'. It's very weird. It's very weird.*  
(Bronwen)

These midwives boast a different skill set than the midwives currently practicing. Bronwen outlined that her practice approach would not meet the expectations of the currently pregnant and those currently practicing. Jackie delineates the series of events leading to the shift.

*Caesars became much safer, and we have readily available analgesia in the community more generally. So, people began to not put up with pain generally. That's been a big change. I've had quite a lot to do with younger people over the years and they're more likely to reach for some Panadol or now they'll talk about tramadol, and 'No. That's a narcotic and you can get dependent. Thank you'. But they'll reach for the Panadol. Whereas the generations I worked with in my early midwifery years, those women never did that. Their mothers had told them to just get on with it. Put the pressure on your temples to get rid of your headache. Put the heat on, put the poultices on, all that sort of thing, because there never was anything except aspirin... So there has been a change in attitude towards putting up with pain. There was a gradual shift, and a shift in belief about labour pain that they shouldn't have to 'put up with it, thanks'. So, they'll just have whatever's going. And so the number of women requesting epidural anaesthetics increased for pain relief not for medical reasons at all. They requested an epidural because they weren't putting up with the labour pains and because they've been told the horror stories, but women generally forget, otherwise they'd never have a second baby.*  
(Jackie)

Jackie outlines that women reach for the easy solution of silencing pain rather than working with it. Glenys shares how this happens—practitioners 'rescue' women with their 'just in case' argument.

*Somebody tells you they're going to run a marathon, nobody gets up and says, 'Oh I don't think you'll do well because you probably won't eat and your feet are too small and you're only 5 foot nothing, and I don't think you'll do well at all. I'll tell you what. I'll just bring the car along and I'll call out the windows and anytime you just want to hop in that car and be taken to the end. I'll be there to save you'. It's like that, it's like the marathon and halfway through the marathon is a hill and you just have to be fit about getting up that hill and getting over that hill. And if you've already planned to have somebody to come and rescue you, then that's what will happen.* (Glenys)

Brenda links the reliance on technology to a loss of confidence in the body and birth. Glenys outlines the process where practitioners 'take over' for women to rescue them rather than support them through. Marjet outlines how reliance on technology disempowers women in their experience of being pregnant.

*Ultrasound scans, I can recall vehemently not having ultrasound scans. And all the work that we did around the harmful effect of ultrasounds. Whether we were right or wrong... But now, well, watching the increase in ultrasound scans... us saying that is taking away midwifery skills, because you're just focusing on the ultrasound scans. And look at how many women have now. Back then you'd only have one and then it moved to three, and now it's like every week if you see an obstetrician. And the Ministry published the data a few years ago, most women were having three to five ultrasound scans. And the technology has undoubtedly gotten better, in terms of looking for abnormalities, but it has created a whole lot of fear in women. (Marjet)*

As participants have indicated, when midwives lack confidence in the physiological birthing process, because of their lack of experience or due to a near miss or a bad outcome, they become more focused on the technology. Further, if they book a large number of women, due to pay, their focus is on the clinical tasks. When midwives have not been supported because they are blamed after a bad outcome, the trend is to align with the medical model and technology, even when the evidence does not support the use of ultrasound or a birth weight chart, as participants discussed above. Essentially, the participants are suggesting that without the relational dimension there is a risk of midwifery becoming detached from its roots as a profession centred on trust and empowerment, and that women are becoming more anxious and fearful of natural birthing processes.

#### 9.4 Midwives Full Circle: Institutional Expectations

This section explores participants' experiences of how the hospital environment has influenced their confidence, practice, and limited their ability in supporting physiological childbirth.

*She was always, 'Oh, no it just always works out, Karen'...She worked at Burwood Hospital because she needed an income and she said to me one day, 'I don't know what it was Karen but whatever it was that I had, it's gone when I work in the hospital. It's gone when I'm here. I*

*can't second guess, I've had a transfer. It's being employed'. She felt she just lost whatever that magic was and that's important because she was totally in charge of her world. She did it how she wanted, her clientele trusted her like there's no tomorrow. (Karen)*

Karen shares a conversation she had with domiciliary midwife, Ursula Helem. Ursula reflected on how in the hospital her 'magic' was lost; she lost confidence, her skills of autonomy, and her intuition eroded when employed and working in the hospital.

Carolyn outlines the process in more detail. She shares that her practice swings back towards a medical model when attending birth in the hospital.

*In the end I wound up looking after women with epidurals and all the rest of it and unfortunately, slowly it starts to become part of the normality of birth, really. And then, the fear starts to inch back into your thinking. And I guess quite rightly so because once you start those interventions and you tip the balance of what's happening then you're opening the door to complication really, and so I think that you probably do need to become a little bit fearful. (Carolyn)*

As Carolyn reflects, she acknowledges what is theoretically understood; that as interventions commence, it leads to what is known as the 'cascade of interventions'. In disrupting the natural physiological balance of birth, Carolyn indicates that this is tipping the balance towards "opening the door to complication". This type of feedback loop reinforces the interventions and diminishes practitioners', women's, and society's confidence in normal birth. What is fascinating about what Carolyn has stated is that she has identified the iatrogenic reasons for fear; the interventions that practitioners are imposing, cause practitioners to be afraid.

Reflecting on their entire career, participants indicated how, over time, their practice has become so much more medically focused. Brenda provides insight into how midwives lose confidence in primary birth after attending hospital births.

*It's completely different from when you're in the sort of factory system of the hospital, where the expectation is that within a certain amount of time there has to be a baby born or else, 'We're going to expedite this birth'. And that's what happens. So, you see babies being born quite quickly because there's synton, because there's this, because there's that. And then when you get into a home situation where it takes a day or two, you're not quite so confident. More people might be worried about what might be wrong. (Brenda)*

Carolyn and Brenda demonstrate the process where a midwife might lose confidence. Rosie (section 9.1.1) had also indicated that experiencing hospital surveillance by the staff interferes with a midwife's confidence and autonomy.

*There's a sense of supervision over your practice... there's a total awareness outside of that room of what's happening, how many centimetres etc... the charge midwives and/or obstetricians have been known to sneak into the supply cupboard and listen through the door to know what's happening... there's a real power dynamic and you're held to account. (Rosie)*

This abridged comment, alongside the others, reinforces Karen's words "there are no longer guidelines, there are rules". When practicing within the hospital system, midwives and women are more vulnerable and conform to strict institutional pressures of time, surveillance, and following the 'rules' which, coincidentally, are the same types of prescribed medicalised practices that instigated the participants to fight for the Act.

## 9.5 The Toll on the Profession

*We have allowed midwifery to be taken by the conventional model. I say as a feminist, I didn't become a feminist so that I could work within male dominated or male design system. What I wanted as a feminist was to be able for women to create structures that work for them. And that's why I guess, for me, the College of Midwives has been very disappointing, and the Midwifery Council, and the midwifery training schools, they've all kind of [been] subsumed by the institutions that don't serve either women or midwives particularly well. Most women, most midwives don't notice. So, there's a very small minority of us kind of charting around the edges. (Brenda)*

Brenda identified that the midwifery profession was reliant on larger institutions for funding, education, and clinical placements to obtain professional credence and credibility. Had midwifery been able to remain existing 'outside the system' and, therefore, 'nimble', the profession may not have become exposed to the level of scrutiny which has subsumed women and midwives. This scrutiny has neither promoted collegiality nor benefited the women-centred alliance (Davis & Walker, 2013). As she continues, Brenda shares that it was the partnership model that was the safety net for midwives to "chart along the edges" of the institutional, patriarchal structures surrounding childbirth and governing midwives. The intention of the Act

was to provide a separate and parallel structure that empowered women, supported midwives, enabling them to prioritise primary birth. Brenda further identifies that through othering midwives have been under attack by the dominant system.

*It's not safe, but what makes it safe often is the woman. They're not safe, they're under attack from their colleagues, they're under attack from the institution but it's that relationship between the midwife woman relationship that makes it worth it. (Brenda)*

When reflecting with participants on their careers, midwives shared insights into factors which affected the whole profession. They reflected on how midwifery could continue without financial investment or support measures being infused into the profession. Suzanne discusses the tensions in today's midwifery profession.

*We're a small profession, a small and poorly resourced profession in many ways. Not in terms of people's passion and capability but just in terms of actual bodies on the ground. And support from the bodies outside midwifery could be doing better to champion us. But we've always been that nuggety cohort of people who just keep on doing it, regardless of what support or recompense we're getting. We're driven by the kaupapa [philosophy] of supporting families and each other and all of that, and it would be really nice if there was a little bit more recognition of the fact that we do just actually keep on keeping on. A lot of midwives are getting to the point where they're saying, 'Actually, I'm not going to do that anymore'. And so, there's a wee tension there for our profession and how we sure that up and get us through to this next little bit. I think we're at a bit of a crossroads. (Suzanne)*

Tensions arise when individuals face a paucity of support and resources. Christine reflects on the current state of the profession (in 2023), compared with the struggles over previous years.

*I think you know when you've been here long enough you see things go around in circles. But I think this is very different how things are now. I haven't seen midwifery in the crisis that it's in now, in my career. There are not enough midwives, not enough people that want to be midwives, there's not enough pay for midwives, they're working in a system that isn't supporting continuity. There's just so many factors, registered nurses are working in maturity, which is great to have someone that's great, they're special but they're different and at the moment senior registered nurses are earning more than midwives on the ward. (Christine)*

Christine and Suzanne highlight that midwifery is in crisis, citing the ongoing strain of chronic under-resourcing, sustained professional scrutiny, and the persistent threat of punitive consequences for perceived non-compliance. They question how much longer the profession can continue under such pressure. According to the participants, the profession is currently at a crossroads with the system being in danger of losing a valuable service that midwives provide.

*It's always been very political, and I think people in the modern day, they don't want things to be political. I think that everybody just wants a quiet life, but why would having a baby be political? Well, it's because of power. Power and control of women doing strong women stuff. So, that's the only conclusion I've been able to come to after all these years. Over 40 years of working in this field, is that actually it just gets up people's noses. They look at it and they think, 'It's not right, all these women out there deciding what to do all by themselves. We can't be having that'. So, at that time you did have to have the strength of your commitment, and I think one of the things that has changed is that the people involved in midwifery, and the people involved in giving birth, they've let quite a bit of that go. And I think the women, the women working as midwives, they don't want to be that staunch, they just want to go to work, do a job, go home.*  
(Bronwen)

Bronwen indicates that people are less engaged and not willing to become involved in politics or leadership positions that have surrounded birth in the modern era. Karen supports this view commenting, *"We've tried and tried and tried to build and support leadership, but nobody puts their hands up these days. It's hard enough to get a leader in the College or to be a chairperson in the region"*.

Rea describes how the consumer involvement process has changed over time from a system that had clear pathways to be active in the politics of health which included forming groups, attending public meetings, and reading newspapers which advertised open submissions for public contribution.

*It is quite different now. We had groups that we needed to form before midwifery autonomy to support the midwives and to support each other in an unconventional birthing option. And quite a few of those women were coming from university and educated, they understood about political and legal processes, so they looked out for the newspaper, the ads of the public meetings coming up, or reports where you could write submissions. Then with Joan Donley, that became really organised. There were networks of newsletters that*

*went out to find out about things that were happening. But at that time there was more of an open participatory democracy. There was an expectation that if you were going to make changes to the public service, you talk to people. And if that's happening now, I'm not in the loop of hearing about them. So, on the legislation side, there's a saying that you can make submissions, but even submissions now... they have a set of questions and that's really difficult if you have a different set of issues to work out. Where to answer those questions and if your answers are deemed irrelevant, it probably goes nowhere. Then it's even more difficult to know how that gets processed and increasingly we know that in fact it may never even get to a human eye, it would be processed by AI, yeah and I think it's a very significant change. (Rea)*

Rea also expressed that the democratic process has affected people's willingness to be politically involved. Whether this is intentional has not been addressed; however, she also mentioned that in the domiciliary era there was a more open democracy in New Zealand.

*We just wrote. Put a letterhead at the top, how many people were involved. What we thought as Christchurch Homebirth Association as it was initially, and this is what we think. Wrote a letter on a typewriter, put it in the mail, and looked at it together. In some ways there's a lot more politics that happens now through social media which is a completely different way of doing a campaign. (Rea)*

Either due to a more complex political process, by design or not, coupled with midwives being poorly resourced and overworked, the collective action has been lost. When inquiring at the Ministry how they meet their commitment to ensure consumer involvement, the response was *"we have an external facilitator who specialises in consumer engagement"* (Anonymised).

Rea mentioned that Joan Donley drove the political agenda and, in her absence, the profession has not had a replacement. Tamarin and Dee, Joan Donley's granddaughter and daughter, were interviewed together. Tamarin identifies the force behind driving the political agenda; Joan's passion and commitment to women.

*I remember I would go and have a cup of tea at Nana's house and woman who had just had their babies would turn up unannounced and have a chat with her. They'd be stressed out and they'd be struggling and they'd be looking to Joan for advice and I used to observe her saying the same thing over and over and over to new mums about diet, about how to look after yourself, usually giving*

*them relationship advice about the men in their lives and things like that. I remember one day saying to her, 'Isn't it exhausting, saying the same thing over and over?' And she was like, 'If I get one woman, if I just get one woman, that's enough!' (Tamarin)*

Dee shares her perspective of what has happened over time. *"But of course, as it turned out as things happened after she died, it wasn't enough because while she's getting one woman, the system's out there is brainwashing hundreds of them"* (Dee).

In identifying the dominance of the institutional system, Dee touches on the mechanisms that align with the fear-based practices used in the larger medical model. Bronwen's experience over time has given her a different perspective as she points to the perspective held from the medical dominating position, *"power and control of women doing strong women stuff... it's not right, all these women out there deciding what to do all by themselves. We can't be having that"* (Bronwen).

Factoring in the power dynamic, specifically for the obstetric lobby to retain control of the funding, on top of the professional monitoring tactics midwives are facing, rules not guidelines, increased surveillance in practice, and reliance on technology, it may be that midwives just want to go home after work. The midwives' narratives resemble a childhood story about a young woman who was given so much work to do she was exhausted and not permitted to attend the ball—a Cinderella syndrome of contemporary midwives.

## 9.6 Conclusion

*We wanted self-employed midwives to be paid appropriately. Because they never got paid well. But we wanted self-employed midwives to be available for women to do the birth and provide all the postnatal care. (Marjet)*

To conclude this chapter, Marjet's comment acts as a reminder of the aspirations for the Act. This chapter has explored the multifaceted consequences resulting from the othering of midwives, as identified in Chapter 8. Othering has seen impacts on professional practice, educational frameworks, and the values underpinning the partnership model and continuity of care.

The metanarratives identified in this chapter are that through othering, midwives are more vulnerable to adherence to paternalistic structures which has caused midwives to develop adaptive strategies to avoid standing out in an attempt to distance themselves from 'othering'. This is reflected in midwives' alignment with the medical model exhibited through an increased reliance on technology which minimises midwives' confidence and traditional midwifery skills. Additionally, alignment to medical practices restricts midwives' professional autonomy as midwifery practices become compliance-focused, perpetuating technology dependency. This links back to the narrative category 'modern maternity, med-ernity'; fundamentally resulting from othering by the Ministry of Health and larger hospital system. The concept of med-ernity reflects participants' ideas that practitioners within the maternity system have reverted to the medical model due to financial withholding, practice surveillance, and threats of reputational damage, all resulting from othering of independent midwives.

This chapter set out to answer the research question: What challenges did midwives face in securing recognition and legitimacy as primary maternity care providers within the healthcare system? The lack of adequate funding has led to workforce shortages; it has fostered defensive practice strategies and fragmented maternity services.

Effectively, participants expressed that the fears outlined by Save The Midwives, in Professor Bonham's 'High-Risk' list of increasing medical management of pregnancies, has become a reality. Although midwives are not referring pregnancies to obstetricians, they are the practitioners who are diagnosing and managing these risks themselves. As with a cascade of interventions and the proposed increased risks in pregnancy, midwives are less frequently using traditional skills, such as palpation to determine foetal size and positioning. Furthermore, participants noted a strain in partnership with the generational shift. For midwifery students, these challenges are compounded by constraints in some educational institutions across New Zealand, with large enrolments and clinical placements reliant on medicalised childbirth.

The chapter has outlined how, because of these systemic barriers, midwives have adapted their behaviours to sustain their practice within an environment that does not value a commitment to physiological childbirth. Over time, the partnership midwifery model has been slowly picked apart by the dominant medical model through othering. Participants identified that midwives were less willing to be political and there are

fewer individuals willing to take up leadership roles. This may be because current midwives are not as robust, or it may be for fear of standing up against the dominant institution and not being willing to risk being a target. Current midwives may also be too tired to commit to any additional work in their increasingly difficult, underfunded, and undervalued role.

However, if anything can be learned from those 'stropy old bags' it is a strategy of safety in numbers, which the New Zealand midwifery was founded upon and will be further discussed in the next chapter. The next chapter focuses on how the participants continued to support each other, while also striving for empowering births across the nation, despite the financial abuse and threats of reputational harm.

## Chapter 10 Narrative Category: Spread Out and Stick Together

This chapter focuses on the narrative category—spread out and stick together. It outlines the professional collegiality and illustrates how, despite facing significant professional internal and external opposition over the years, the participants collectively advanced and fortified the midwifery profession. The metanarratives identified that participants maintained strength and commitment to their cause of increased health literacy, supporting midwives, and fighting against the patriarchy; hence, the narrative category spread out and stick together. Throughout all the years these midwives and consumers have worked together, they have infiltrated central government, shaped midwifery education and governance, and strategically embedded midwives, many of whom had roots in domiciliary midwifery practice and Home Birth Associations, within medical institutions. These actions speak to spreading out in support of midwifery. Within these positions, participants worked to safeguard the profession and promote primary birth. Their efforts included actively protecting midwives and students within hospitals and educational settings, and in the community they championed empowering birth experiences by continuing to raise awareness and educate the public; thereby reinforcing the notion of ‘stick together’. A synopsis of the chapter sections can be found in (Appendix E) in the story map grid. The chapter concludes with participants reflecting on the experiences which sustained their passion and commitment to midwifery, despite having confronted decades of challenge and scrutiny.

### 10.1 Midwives as Guardians: Advocating for Each Other

The participants discussed having been in positions over the years which required them to stand up for other midwives in a protective manner against the medical establishment. Carolyn’s PhD, exploring burnout amongst independent midwives, made her more aware of the signs when her colleagues may be experiencing a difficult time. She outlines a typical day of the community midwife and hospital employee interface, exemplifying the competing priorities between practitioners’ roles and responsibilities.

*I remember I was in the birthing room and because my women tended to be very quiet in labour and I found women that were so*

*distressed and yelling and screaming really traumatic for me to even hear. And the woman in the next room [was] very vocal and very fearful and had a really tough time having her baby. When I came out, I saw my colleague who was with her and I said, 'How are you? That sounded like it was pretty hard going for everybody'. She said 'Oh yeah I'm a bit wrung out but anyway, I've got another woman in labour coming in'. I said, 'Have you had anything to eat or drink?' And, 'No. I haven't'. And I said, 'Well I'll make you some tea and toast'. I walked past the charge midwife, and she said, 'Oh, who's that for?' And I said, 'It's for [the midwife]'. And 'Oh? You're making her tea and toast?' I said, 'Yes, she's got someone else coming in and she's just been through what's been quite a harrowing birth'. And it was like, 'Oh, she hasn't been here that long'. And I said, 'When she comes out try looking at her face instead of your watch and then you'll have an idea of how difficult that birth was. And yes, she does deserve a cup of tea and toast'. (Carolyn)*

Although Carolyn recounted the situation in a non-judgmental manner, simply describing the events as they had unfolded, her experience highlights the disconnect between the institution and community practice. This is particularly demonstrated when the focus shifts from the human element of birth to the technical aspects of service delivery. Carolyn's experience again points to the metanarrative of 'othering' of midwives (Chapter 8) and the prioritising of medical over traditional midwifery skill (Chapter 6).

Also, identified here is how community midwives shelter each other as a mechanism of support while, at the same time, they shoulder the burden of remaining collegial with the hospital midwives. However, support from the hospital is not forthcoming. For example, a community midwife does not get a break unless the hospital charge midwife provides a midwife to relieve them.

Karen recalls using group tactics for protecting both patients and midwives within the institution. Although this instance was before the Act passed, the collective practice of aligning with consumers and creating support en-masse was an evident strategy of protection used by participants throughout their careers.

*Twelve midwives from labour ward made an appointment with the management and we said we'd heard a rumour that they were going to appoint this certain obstetrician as the next chief medical officer. We told them that we were all going to leave if they did because he abuses young women. We told them that if a girl is young, he puts his hands all over her, he does episiotomies when they don't need them,*

*and we're not having a bar of him. That was the end of him. Just took 12 of us. We also did the same thing about episiotomies, we went on strike, we said, 'No. We're not going to do episiotomies', 66% of women had episiotomies and that was the guideline, you had to do an episiotomy on every primip. We did the same with inductions, so really in a matter of months we changed Christchurch Women's from being the worst interventionist hospital to a reasonable one. If you all do it together, they can't sack 12 of you. But you do have to have somebody in the hospital who will lead and actually take it on. They do have to have personal authority, they have to be personally secure, they have to know that they might get sacked, and they'll suck it up and that's hard and always has been. (Karen)*

Karen's statement touches on key points within this research; by collectively sticking together, these participants created the midwifery-led model that was beneficial for women and midwives. By doing it together, they were able to reduce interventions imposed by the 'medical men'. As Brenda stated, women did not want to go into hospital and "*let you men fiddle with us*" (section 6.4). Karen mentioned how this unethical behaviour only changed when 12 midwives stood up against the system to prevent the doctor from becoming the chief medical officer.

Karen's account identifies that to create change, the midwives banded together. As Karen says, the hospital cannot 'sack' all 12 of them; thereby bringing safety in numbers. She insists that there needs to be a leader to take on the fight, to sustain the change, one who might then become the scapegoat if the hospital retaliates. Perhaps what Bronwen (section 8.4.1) was missing when she challenged the obstetric practices from within the hospital and 'against' the system was an organised team dynamic, as she was the only one that was paid to leave.

### 10.1.1 Midwives Advocating in Education

This section brings in a similar strategy to advocate for midwives in education against the wider faculty. Participants also discuss how they sheltered students. In a similar 'safety in numbers' strategy, Jackie describes how midwifery lecturers would use a self-protection mechanism to show solidarity and support for each other, when the direct entry programme was developing at Auckland University of Technology.

*There were three of us and we used to go everywhere and in the faculty with our arms linked. We would go everywhere together and*

*sit in the meetings together, like a little block, 'Here's the midwives'. We got up people's noses I'm quite sure. (Jackie)*

Despite consistent setbacks, it never deterred participants from moving forward, becoming creative and finding new ways to support each other for mutual benefit.

*We had collectively talked about embedding a teacher in the delivery unit. They were desperately short of staff, and we were having trouble covering the supervision of students. So, we put together a proposition that said we can help your staffing issue, especially the mentoring of your new staff by having a joint appointment. So that joint appointment person was employed by us [university], and she was seconded to the hospital. The hospital paid for half of her wages and so that meant that they could use her as the mentor for their new staff when there were no students in the unit and that worked really well. That was a huge achievement but that was pretty revolutionary at the time, but we had to convince a lot of people. I did a lot of convincing over the years and so did the others. It was really important to just keep it moving. (Jackie)*

While the midwives, as a profession, were waiting for clinical shortages to ease and the pay to increase, the participants continued working towards assisting each other within the profession.

*Christchurch set up clinics. So for instance, when I worked at the polytechnic, I would have a clinic at Christchurch Women's. I just went in there and said I wanted an antenatal room for my students. 'We'll have our own clients'. And nobody had a hissy fit, they just said, 'Oh, whatever. Okay, that's fine, do your work' sort of thing. And the same the whole of the South Island, Nelson did that, Dunedin. (Karen)*

The participants became creative in finding solutions to support students in clinical areas when students needed placements. They communicated about what strategies they could use for the student's benefit.

*I've always worked with students, right from when they were looking for placements for students over the years I have worked with many students. I'd take them out with me in practice and sort of towards the end if they had a difficult student I would be asked if I would take that student and also students who had had a poor time, and had lost their confidence, I had a few of those and then I did mentoring as well. I really enjoyed the students, there was the odd one where I'd wonder, 'How far are you going to get?' But most of them were just delightful and that 3-month placement made my life a whole lot easier because once you had taught your student, you'd get into the*

*birthing room, and you'd turn to do something, and the student had done it. Then students recapture that magic too and they come away on that baby high which is really infectious. Also to take students out to home births and they saw a form of birth they hadn't experienced before so, always found it a joy to work with students... [After my PhD] I became a lot more stand up for midwives, very protective of my students and of my new grands that I was mentoring, that they got treated properly by obstetricians. (Carolyn)*

This section has outlined the participants' commitment in educating midwives for future generations, and their advocating and proactive guidance in student learning by modelling collaborative working strategies.

## 10.2 Consumer Dedication to Partnership

In the same way that Sian and Bronwen expressed the Ministry's othering towards midwives, Marjet's account indicates how she was able to support independent midwives within the hospital system when they were othered.

*I used to manage the complaints around the self-employed midwives. I was always able to see things from the midwives' point of view. When you work in a hospital, people are always pretty quick to blame the midwives. 'That midwife, she didn't come in for the birth?' And then I'd look and 'Oh, hang on a minute, did you call her? Did you actually call her? She's not going to come in if you haven't called her'. (Marjet)*

Marjet identifies that a flaw within the system is that hospital midwives are 'quick to blame'. As Marjet continues, she notes that despite independent midwives representing the largest group of practitioners responsible for bringing births into the hospital, they are consistently excluded from considerations in the design and planning of maternity services.

*People here don't realise that midwives, their car is their office mostly, so people will say, 'we'll get them to login to [hospital programme]. And it's like, from where? And my feeling is 'Why should they? Why shouldn't we?' Given that self-employed practitioners do 75-80% of the work here, why shouldn't we devise a system that works for them? Where we notify them when the woman's discharged, for example, and have a system that works for the midwife. (Marjet)*

Most midwives do not have the same wrap-around support as doctors, such as administrative staff to assist with logging into hospital systems. This creates a disparity in workload. While one practitioner group has seamless access to patient information, midwives are structurally excluded. Despite this systemic limitation, independent midwives are often perceived as 'lazy' or 'unwilling to do their job' when they rely on hospital staff for essential updates. This perception contributes to the sense that midwives are imposing on already overburdened hospital midwives, further straining interprofessional relationships and reinforcing the 'othering' that independent midwives routinely experience within institutional settings.

Marjet describes how as a consumer working within the institution she has chosen to support independent midwives in their role. She takes the view from their perspective when recognising the limitations of the system and of technology.

*A midwife was using a computer system which has now rectified its problem, whereby the gestation did not match the birth weight. So, she had an estimated foetal weight, and she thought that it was okay. But actually, on the growth chart, there was an error. And she brought this baby in here and she was absolutely criticised by the obstetrician here for getting it wrong and for the poor outcome. When actually it was the software. I followed that up, that midwife came here in tears. I knew enough about the computer systems to know what the problem was. (Marjet)*

The immediate response is to blame the midwife, rather than to examine the facts or consider systemic influences. Even when the midwife has followed the 'rules', she remains the target of blame. Marjet continues to explain what happened.

*I thought that there needed to be an apology. That employed obstetrician needed to go back to that midwife and say, 'I'm sorry'. I had proved the issue with the software. You could have all the software and there are lots of bugs in it. There were some investigations, we supported [the midwife] and to her credit, she kept going and she's still practicing. But for some people that would be enough to break them. You've got to have a lot of confidence to come back into this organisation after you've been criticised. (Marjet)*

The increase in use of technology did not make for a better outcome, in this case. However, the solution was to improve the software, demonstrating a continued faith in technology, rather than to also encourage a traditional midwifery approach to

assess foetal weight with one's hands. The response reflects the dominant medical model in which faith in technology is upheld as the gold standard, despite not guaranteeing ideal outcomes. In this context, midwives are routinely othered and marginalised, their professional judgement undermined.

Marjet, having been a consumer and advocate for midwives, was in the unique position to continue advocating for independent midwives while working inside the hospital institution. However, at the time of her interview in 2023, Marjet was in the process of slowly retiring and handing over aspects of her role. The institutional knowledge and support that Marjet holds, may soon be lost at that hospital for independent midwives.

### 10.3 Collectively Supporting Normal Birth

*The whole natural childbirth movement really got underway, and it was a broad thing. It was women, it was midwives, it was national, it was international, it was local. But here it was driven by the women wanting better maternity care that recognised and supported natural processes. And the midwives who wanted autonomy. And the women thought they could get what they wanted as well. (Jackie)*

Jackie's quote offers a reminder of the purpose of the Act; a shared commitment to natural childbirth over the years. The participants expressed this both through their involvement within the profession and in attending births.

*I gave a talk to the obstetricians at Hamilton hospital and illustrated it in a flower. I held up the flower with petals and for each act that happened to those people, I tore a petal off the flower. So, what we ended up with was a petal-less flower. 'This is what you do to women. This is what you do to mothers when you treat them like this'. The whole room was silent because it was the most graphic demonstration. It was my way of demonstrating, 'Think about what you do. How you do it to mothers and couples', and I don't know whether that's changed. (Glenys)*

Jackie identifies a shift in the mindset of the medical community but shares that the social expectations on women have also changed. Jackie mentions a colleague, Debbie, having to fight for her home birth simply because of her age. Having a midwife to support her was the only avenue to having the birth she wanted, and Joan Donley's support in attending made the home birth an option.

*Women are now much older; they're now over 30 when they start their families. And you know Debbie XX, she had her babies when she was 35 or 36 and she was considered so high risk. She had to fight for her home birth. And she only had Joan Donley on her side. That was good because Joan Donley was, you know, she really was an amazing woman. You were an elderly primip at 25 when I was a young woman, because my generation, I'm 76 now so in my generation, we all had our babies between 18 and 25 and if you haven't started your babies, 'your nursery', that was the language, by the time you were 22 or 23 then all the old ladies would ask you, 'When are you starting your nursery? Get on with it. You're getting too old'. (Jackie)*

Jackie also indicated how the older ladies would put young women in their place by telling them to hurry up, you do not have much time—'you're getting too old'. Age discrimination, as it would be described now, indicates a shift in medical management and societal opinion around birth and a woman's age. Joan Donley was seemingly alone in supporting Debbie in her home birth; however, in this one generation after the Act, having a first baby (a primip) at 36 is much more common, and perhaps seen as less 'risky' than it was in the 1990s and earlier.

Brenda shares her experience of attending the birth of her grandchild. She intervened when the midwife suggested transferring to the hospital. From Brenda's perspective she observed that her daughter, the labouring mother, and baby were both doing well, although progress was slow.

*Everyone's been awake all night, and the midwife says; lucky my daughter was so endorphined out, so she didn't hear. She was perfectly alright and one of the benefits of being young and having no expectations, she'd been present for the births of her younger siblings and so she didn't really know about time and things like that, she was just labouring and having her baby. And the midwife looked at me and said, 'I think we might need to transfer'. And I don't know what I said but she said to me, 'I felt like I'd run into a brick wall'. I said [something like], 'There's no way. We are not taking this 18-year-old to the hospital. She is not going. You know if we go in now, she's gonna have a caesarean section. And, she's not having a caesarean section. The baby is alright. She is alright. We're staying here'. Then I said to my daughter, 'Things are taking a bit long now, you need to get on with having the baby. I'm going to call a friend who's an acupuncturist and ask her to come'. Just to calm the midwife down as much as anything, calm the room. And by the time the acupuncturist arrived, she was pushing the baby out already. But again, it's that thing, the midwife, she is a friend and colleague, I'd worked with for many years. I believe that she was tired and thinking, 'How much*

*longer is this going to go on?’ And she’d run out of steam, not that my daughter had. (Brenda)*

As Brenda indicates, the midwife felt like she had come up against a brick wall when suggesting transferring to a hospital. Brenda’s position was that the mother and baby were alright and the decision to move was perhaps to encourage labour along. This shows that to have a home birth, even with a midwife that offers birth at home, increasingly what happens is that sometimes there also needs to be someone advocating strongly in the moment, to support the midwife and remind them that the situation is within normal limits.

Christine explains that having strong midwifery support within the institution can protect primary birthing.

*At Christchurch all the bookings were triaged at Christchurch hospital and if women on their booking were normal they were told that they needed to birth in the primary unit or home rather than come into the hospital. So, actively discouraging people from going there, which I think was great. I’m not aware of that happening anywhere else. (Christine)*

Norma became the midwifery manager at Christchurch Women’s Hospital and implemented the triage procedures which Christine speaks of. The College of Midwives national office, based in Christchurch, may have afforded the strong collegial support underpinning the midwifery model. Other hospitals have not been able to be successful in implementing midwife-led approaches. Bronwen made attempts to incorporate the same at Timaru hospital (section 8.4.1) and was paid to leave.

*This job came up and I thought, ‘Actually I might be able to make a difference’. The mechanisation of how these organisations work, looking in from the outside doesn’t give you a full understanding. The politics are extraordinary, I thought politics were bad at the national office, they’re nothing like what goes on in these places. Deb Pittam had gone to North Shore, then she went to Northland, then Auckland. It is great having strong midwifery leaders in hospitals and specialist services. (Norma)*

Christine and Norma suggest that for primary birth to be successful the hospital needs to maintain a bounded approach in triaging and admitting patients when clinical indications present that require hospital services or treatments. This advice needs to

come from the hospital management to support the midwives so that they can successfully perform their role. Susanne expands on this idea.

*We, as midwives, have a philosophical mandate, absolutely, to provide enough correct information for people to make good, informed choices about place of birth. What we educate is for people to understand that if you're a well person, who doesn't have complexity in pregnancy, then the least harmful place for you to give birth to your baby is in the primary setting, home or primary unit. We educate around the evidence for that; we see that as a huge responsibility for midwives to inform people about that. (Susanne)*

There seem to be a multitude of barriers preventing primary birth and there needs to be support at every level. Suzanne suggested there is a lot of information around supporting birth in the primary setting. However, if the midwife does not have the exposure to birth in the primary setting, or does not choose to work in the primary setting, or their last experience was a bad one, or the woman is looking for a reason to 'not do this' (section 9.1), primary birth has multiple reasons stacked against being a viable option.

Bronwen explains what is required to support primary birth which reinforces Suzanne's mention of a midwife's philosophical mandate.

*Strongly believing in the ability of women to give birth to their babies. And the best way to do that was to leave them alone and give them all the support that you could and to intervene when it was required, not intervene because it was expedient. And recognising that the interventions actually lead to more interventions and that is well documented and well researched, and everybody seems to have completely forgotten that, or aren't at all interested. (Bronwen)*

Although Bronwen has discussed this in a theoretical way, Brenda (above) indicates how this focus on intervention happens when primary birth is taking longer than a practitioner is used to. Both Bronwen and Brenda mention the time factor as the underlying motive to expedite birth possibly due to an increased number of births an independent midwife is responsible for, and/or due to the financial constraints, or when hospital staff are not able or willing and the midwife is exhausted.

## 10.4 Sustaining the Flame: Continued Devotion to Midwifery

*Midwifery is a living, breathing profession that grows and develops in relationship to each woman we connect with. (Pelvin, 1996, p. 14)*

As the findings conclude, participants' stories reveal that they never gave up on their passion to support empowering childbirth experiences. They protected the profession in the face of othering and through generational shifts of consumers and midwives and student graduates who may not have had exposure to primary birthing. They continued their commitment to their core belief of what birth could be within environments that made them feel as 'other'. Although I did not explicitly ask why midwives continued this work in the face of such strong opposition, many participants offered the aspects that enabled them to continue. Bronwen describes the realisation of how normal birth slotted into the daily life of the family, compared with hospital deliveries.

*That was one of the big revelations for me when I went to people's homes, it was like, 'Well, this is just so normal'. Woman wakes up in the night, she's in labour, she calls the midwife, the midwife comes around, the baby gets born. No one else in the whole world knows that this has happened. It's just wonderful. (Bronwen)*

Bronwen describes having attended her first home birth. The normalcy had such an impact on her, she immediately switched careers from hospital maternity nursing, with a stable income, to becoming a domiciliary midwife and attending home births. For Bronwen, observing the normality of the low-tech labour, the empowering experience for both her and the mother, was so impactful it became her lifelong career, one that she fought to make a legal reality.

Sian outlines the connection with her colleagues and the consumers.

*What created my sense of home, my sense of belonging, was being part of midwifery, and it was a very exciting time to be part of midwifery. This huge renaissance, huge amount of political change and to be part of that was a complete privilege. But also, the people who I had around me, it felt like a tribe of people who I completely related to. (Sian)*

Joan and Susan outline the empowering experience of being successful in achieving the law change and practicing as independent midwives during the early years.

*We were just so blessed to have gone through that autonomy and to have experienced what it was like before and to have fought for something and then worked incredibly hard and to have it, that was just fabulous. (Joan)*

Susan extends these ideas bringing in the responsibility of the political renaissance and the independent practice, *“it wasn’t only the development of your own practice; it was the development of midwifery as a profession and that was extraordinary to see the incremental change over time. There was no legislation when we started, absolutely nothing”*. Susan recounts that they not only developed the profession, but also the standards and guidelines surrounding the midwifery scope of practice. This included funding structures and developing aspects of integrating health services in prescribing, referring to specialist practitioners such as GPs, Well Child providers, or paediatricians.

Joan Donley’s daughter, Dee, and granddaughter, Tamarin, spoke about Joan, capturing both her persona and the time in which she lived.

*I think Joan just got the bigger picture, she got how sacred woman and birth and all of that were, and why it was so worth protecting. Whereas, I’m sure other midwives do get that, it just takes so much to be able to come to that level of understanding. (Tamarin)*

*The other thing too is that a lot of the other midwives were married with kids. (Dee)*

*Yeah, it’s true she was at a certain stage in her life where she was free to... she didn’t have anything to lose, did she? Her kids weren’t going to get taken away of her and it wasn’t going to threaten her marriage. (Tamarin)*

*It was too late for all of that [laughs], she was financially secure, she owned her home. She was happy living where she was. (Dee)*

In amongst these brief statements, a snapshot of Joan is revealed. Joan had immense knowledge around a sacredness of birth, that was *worth protecting*. However, Dee also identifies what that level of commitment may have ‘cost’ other midwives; these statements talk about Joan having little to lose. The mention of her not being at risk of her children being taken away and a marriage that was not under threat simply due to her commitment to her work, like the *other midwives* may have been, speaks to the

level of personal threat that participants were confronted with from othering and medical dominance.

Jackie and Carolyn share their personal feelings of how, in just two generations, their professional perspective changed so much.

*I just loved it, yeah, just loved it. I was just talking to Liz Smythe the other day, I think we had the best of it, our generation, because we had the development, but we also had our grounding back when women were just having babies naturally. There were lots of small maternity hospitals scattered around the country. (Jackie)*

Jackie touches on the fact that natural childbirth was the norm at that time in education and practicing in small maternity units. When there were small maternity hospitals around the country, women only went to larger tertiary hospitals, such as Christchurch Women's, when medically necessary. As the low tech primary birthing units were common, in terms of sociality, for practitioners and the public the perception of childbirth was that birth was normal. The belief that birth was a medical event shifted when labour and birth moved into the larger hospitals towards the 1940s and the treatments during labour became the standardised medical model.

Carolyn identifies the shift in social consciousness between midwifery having been a vocation compared to becoming a profession.

*Nursing was seen as a vocation, becoming a 'nun' so that you put your own life away and you were completely given over to the care provision. I think midwifery, to a certain extent, had some of that as well and that's very exploitative. I think there's much more of a business-like approach now, which in some ways is healthy because you're not going to get exploited by that vocation drive. It also means birth as an intimate personal, profound experience; if you are treated like you're getting a tooth filled, a lot of the magic gets lost. It's finding that balance between self-protection and thinking logically and managing your practice so that it's sustainable. But also, if there was no magic why would you get up at 2 in the morning? And there always is a magic to me. I'm always utterly shocked when this tummy turns into a baby. (Carolyn)*

While Carolyn discusses the magic of birth; she also identifies the potential exploitative nature looming over the service vocation. While Carolyn reflects on the importance of midwives establishing boundaries in practice by drawing comparisons to more

transactional models like dentistry, her commentary on vocation gestures towards a deeper, gendered issue. The historical framing that midwifery is a self-sacrificial calling, rooted in 'feminine' roles such as nuns or carers, has romanticised the labour and contributed to its systemic undervaluation. In contrast to the higher status and remuneration afforded to doctors, by the Ministry, midwives have faced persistent challenges in negotiating improved working conditions and equitable pay. If midwives are viewed by society that their position is service but not work, a vocational status, akin to being a nun, then the financial reimbursement is also viewed at a lesser value, and exploitation is more likely.

Suzanne shares how her colleagues bring diversity to the whole profession.

*I love that midwifery takes people to all sorts of places they might never have anticipated. There are so many roles that midwives can occupy where our worldview can help others to see value in a good start to life. I think about midwives I have known who work in politics, in quality assurance, in war-torn countries, in homes, in hospitals, in policy-making, in research, in fiction and non-fiction writing, in movies, the list goes on and on but in every space that midwives occupy, they bring a certain nuanced understanding about getting alongside, being with, making space for transformation, and that's what I love most about midwifery. (Suzanne)*

These individuals showed unwavering commitment to empowering childbirth, sustained despite generational shifts, professional othering, and declining primary birth. The varied, yet collective, experiences that Suzanne mentions are represented across all participants in this research, highlighting the narrative category—spread out and stick together.

## 10.5 Conclusion

This chapter has highlighted participants' unwavering commitment to advancing and sustaining the midwifery profession, even in the face of significant and ongoing opposition. Their reflections reveal a collective effort to advocate and support midwives and students. Participants emphasised the vital role of community engagement, with consumers actively working to support the profession by fostering public education and awareness over time.

The research question addressed for this narrative category was: How have participants sustained their commitment to physiological birth and midwifery autonomy over time, despite systemic constraints and professional marginalisation? The metanarratives identified in this chapter include that, over the years, participants have maintained strength and longevity in their commitment to empowering women through their birth experience, supporting midwives, and fighting against the patriarchy. These actions are reflected in the chapter sections of midwifery guardianship and advocating for each other through physiological birth, a dedication which links back to the narrative category—spread out and stick together.

The chapter also explored how participants remained steadfast in their advocacy for natural childbirth, demonstrating resilience and dedication to core midwifery principles throughout the years. It concludes by centring the participants' personal reflections on the experiences that sustained their passion and love for their work in midwifery, despite the numerous challenges they encountered. These insights emphasise the enduring strength and unity within this group of individuals and their ongoing commitment to serving women and their families.

This chapter has shown how the enduring presence of paternalistic structures has been met with continued resistance from the participants. They have maintained their support for women and midwives within a system that prioritises the medical model and have continued to educate and maintain their belief in woman and childbirth. The findings concluded with participants reflecting on the passion and sense of purpose in their work, describing the 'magic' that kept their dedication alive over the years. In the next chapter, I discuss these findings and unpack their broader significance to the midwifery profession.

## Chapter 11 Discussion and Conclusion

This thesis provided a historical analysis addressing the research question: “What aspirations did the study participants have for maternity care, and how did they envision their role in shaping its transformation?” Through narrative analytical methods, data were collected from a diverse sample of consumers and midwives across New Zealand, offering an original contribution to the historical understanding of a practice shift over time in the overall maternity system, midwifery practice and education, and funding policies within the profession.

In this, the final chapter, I focus on the research findings which raise critical questions regarding the temporal evolution of the midwifery profession in New Zealand from 1990 to 2023, particularly concerning the interplay of midwives and the enduring influence of hospital-based practices. Early pioneers of midwifery achieved significant progress, such as changing the law, but not all midwives embraced the practices of natural childbirth. Many midwives had not experienced normal birth, and they lacked trust in the physiological process. The partnership model in New Zealand developed out of a deep collaboration with women, reflecting the collective effort to establish woman-centred, midwife-led practice standards.

Over time, participants’ efforts continued to be undermined by hospital-trained midwives who transitioned to community midwifery without having unlearned the medical practices and the hierarchical mindset. After the Act passed, the med-wives brought with them fear of childbirth, practitioner-led approaches, and, in some cases, were ultimately unable to truly adopt the partnership model. The metanarrative being that within the maternity system the patriarchal medical hierarchy continue to dominate maternity services; characterised by rigid protocols, rules not guidelines, and embedded surveillance. Participants, who were deeply unsatisfied, challenged the dominant medical model from outside the system.

Within one generation from the Act passing, partnerships became stressed with the millennial mother; again, participants identified a shift in women’s expectations of the midwife as someone who does not have to jump when the woman says jump, while at the same time noting an absence of personal agency and desire for empowering birth.

Unlike their mothers, the new generations of women do not share these desires of self-agency and ownership of their pregnancies and birth experiences. Instead, they are more passive in their relationships with midwives, quicker to complain, and less inclined to question the overuse of technology in maternity services. This relationship was described as a faith, which further strained partnership and contributed to the reliance on interventions.

The Ministry of Health played a pivotal role in driving these challenges. In 'othering' midwives they have failed to financially reimburse midwives in accordance with legislation. In neglecting to adopt cost-neutral strategies to improve working conditions, the Ministry exacerbated existing issues. The lack of clear delineation between primary and secondary care further blurred roles, enabling doctors and hospitals to encroach on primary health services. Obstetricians often provide unnecessary treatments and reap payments that are three times more than a treatment for individual patients, while midwives are unable to receive payment for services they have provided. Meanwhile, hospitals routinely deliver tertiary-level care to women with primary health needs. Despite the intention of the Act to prioritise primary birth, the Ministry's culture continues to favour the medical model of childbirth and undermine primary birth.

Midwives who deviated from recommended practice protocols face heightened surveillance and potential threat of a complaint. The culture of mistrust and othering within the Ministry, perpetuate this toxic behaviour by proposing to develop and enforce accountability measures aimed at midwives. The Ministry employee stated; *'We have virtually no accountability measures within the notice, so without accountability. There are no accountability measures. So, this is something that we're currently looking at, where are our accountability measures?'* These accountability measures seem to be the finite solution to solve every and all concerns within maternity, when the Ministry could instead reflect on their own accountability towards midwives and The College.

Institutional surveillance, a mechanism to maintain rigid adherence to medicalised 'rules' disguised as guidelines, contributed to midwives curbing their own practice. This reflects the metanarrative that midwives do not want to stand out as their practice is

under surveillance; thereby, controlling their practice (behaviour) and perpetuating the increase of medical technological reliance. This is a systemic failure to recognise and support midwives as autonomous professionals to provide safe and effective primary services.

Alongside systemic failures, unchallenged fear, particularly of the unknown, underpins much of the control midwives and women continue to be exposed to through the medical model by obstetricians, hospital staff and The Ministry. The ever-present 'just in case' rationale dictates practice, including the practice of over-working, and drives the unnecessary interventions. Defensive practices have become normalised, although not for the benefit of women or babies, but to protect practitioners from the potential of reputational harm. Midwives are aware of reputational whispers, a subtle but powerful way in which colleagues monitor one another to placate superiors, ensuring conformity which links to the metanarrative of surveillance and control.

Independent midwives operate without the shield of institutional support which leaves them vulnerable to surveillance and control in fear of a complaint. The College of Midwives, in its attempts to create professional cohesion, has historically functioned as a protective reinforcement against larger institutions. However, the Ministry's refusal to liaise with the College implicates them in othering.

Ultimately, financial constraints to the midwifery profession minimise women's agency, compelling them to follow instructions rather than allowing informed choices; for example, when an independent midwife does not offer primary birth options, like home birth. Although, the Act designates midwifery autonomy of birth place decisions, professional guidelines require midwives to "demonstrate that they can practice the full scope" (Pincombe et al., 2010, p. 243) which includes primary birthing spaces. However, it is the hospital institutions, and the Ministry have made conditions for midwives to practice their full scope near impossible.

Faced with inadequate and inequitable remuneration from 1993 to the present day, in 2025, midwives have developed strategies to maximise finances from an outdated fixed structure. These strategies included increasing caseloads, which dilutes their ability to develop meaningful partnerships with women, and fragmenting services rather than adhering to a continuity-of-care model. These practices are observed by

students during placements who lack demonstration of the theoretical aspects of traditional midwifery due to a shortage of midwives. Thus, partnership, as taught in universities, cannot embody the core tenets as envisioned by the study participants under the Act.

Despite these challenges, the findings chapters identified that the participants sought to create a system grounded in evidence, support midwifery-led primary practice, and use research to educate practitioners and the wider public. Within the hospital system, both midwives and women are expected to comply with all medical treatments, despite being offered 'choice' and 'informed consent', not because of any tangible evidence supporting hospital-based birth, but because of patriarchal structures of compliance and control. The system operates through invisible, yet powerful, mechanisms that deter midwives from opting to deviate from the norm, ensuring that maternity care remains tethered to institutional control rather than implementing the evidence which identifies benefits of primary birthing. If institutions, such as the Ministry of Health and hospitals, were to focus on tangible evidence such as cost-analyses, primary birth statistics, and the clear benefits of midwifery-led care (as Christchurch Women's Hospital has implemented), the justification for the current system would unravel. Yet, the metanarrative of dominant fear-based control ensures that these tangible realities remain overlooked.

The insights emerging from this research reveal that systemic and cultural forces, rather than evidence or clinical need, have shaped the delivery of maternity care. The narratives of midwives illustrate how professional autonomy has been steadily undermined by institutional hierarchies, rigid policies, and inadequate remuneration structures. These findings inform the recommendations presented here by exposing the disjuncture between the Ministry of Health's stated commitment to primary maternity care and its continued prioritisation of hospital-based, interventionist models. By critically examining these contradictions, the research underscores the urgent need for policy reform that restores trust in midwives as autonomous practitioners and reorients maternity services toward woman- and family-centred care. A restructured funding model; one that recognises the complexity and relational nature of midwifery work; would not only sustain the profession but also strengthen continuity of care and improve outcomes for women and their families. Likewise,

shifting the cultural discourse from surveillance and control to collaboration and respect would enable midwives to practise to the full extent of their competence, ensuring that the primary purpose of maternity care; to support normal birth and uphold women's choices; can be realised.

In summary, the findings illustrate how systemic factors, including social, financial, and institutional dynamics, have hindered the full realisation of the Act as envisioned by its architects; many of them participants of this research. These factors have further limited midwives' ability to practise within a fully autonomous scope which hinders women from experiencing the full potential of informed consent.

### 11.1 Research Implications and Recommendations

This section identifies the implications of the metanarratives outlined in the thesis and presents recommendations to address structural, cultural, and policy-level reforms required to restore integrity to the maternity system and realise the legislative intent of the Act on midwifery practice. The metanarratives represent the main ideas expressed within the Findings chapters. Within those chapter sections, the categories divide sections and organise experiences expressed by participants. Effectively, the categories were used to outline the metanarrative, which are the broad ideas of the whole story. The research implications and recommendations are presented based on the metanarratives as they represent the broad concerns raised within this research.

The discussion centres on critical priorities; prioritising primary birth, restructuring financial reimbursement models, challenging the culture of surveillance and 'othering', clarifying clinical care pathways, and ensuring policy alignment with legislation.

#### 11.1.1 Prioritise Primary Birth

This research draws attention to the Ministry of Health's neglect in promoting primary birth. Policies must actively prioritise primary care for individuals who are not presenting with clinical indications. This will rebuild trust for practitioners and pregnant individuals in the natural birth process. Implementing evidence-based practices, such as refusing primary birthing services within a tertiary health setting, as Christchurch Women's Hospital has done under Norma's management, has been shown to build confidence with practitioners and community. Additionally, it will

increase primary services for student placements to ensure they are prepared for the holistic scope of maternity practice.

A further study needs to focus on translational research where implementation of high-quality research about place of birth, and pedagogical and educational best practices for New Zealand's student midwives are the focus. Universities could examine how successfully their student placements prepare midwives to advocate for physiological birth and resist the dominance of the medical model.

### **11.1.2 Restructure Financial Reimbursement Models**

The study highlights the financial strain on midwives and the negative impact of inadequate reimbursement on their practice and the wider profession. Addressing this issue could involve restructuring payment systems to fairly compensate midwives for their workload. This adjustment could improve midwifery retention rates, enhance quality of care, and enable midwives to offer continuity of care without being forced to overextend their caseloads or fragment services.

Exploring the Ministry of Health's perceptions and attitudes towards maternity services and midwives, and their accountability, is critical for a more complete understanding of systemic issues. Research could examine the impact of the Ministry's recognition (or lack thereof) on midwives' working conditions, financial remuneration, and professional status. Interviews with key stakeholders within the Ministry could shed light on their awareness of midwifery challenges and their willingness to address these concerns.

This work can commence with a thorough independent economic evaluation of New Zealand's maternity system and the current model of care with a focus on the activities and responsibilities of the independent midwife. Such economic evaluation would need updating every decade to account for a changing demographic.

### **11.1.3 Challenge the Culture of Surveillance and 'Othering'**

The findings highlight how the surveillance culture and 'othering' of midwives have eroded professional autonomy. Addressing this issue requires a cultural shift within the Ministry of Health and the wider healthcare system, replacing punitive monitoring systems with supportive frameworks that value and trust midwives' expertise.

Guidelines must be reframed as flexible tools rather than rigid rules, fostering a collaborative, rather than adversarial, approach to maternity service providers.

Further research regarding hospital accountability in promoting birth practices could include investigating how hospitals protect and promote the philosophy of normal birth in practice. Research could explore whether hospital policies and practices align with evidence-based care, and the extent to which they support the midwifery partnership model.

#### 11.1.4 Clarification of Clinical Care Pathways

The findings reveal a critical need for a clear delineation between practitioner responsibilities. Hospitals must establish clear boundaries for services, indicating that private obstetric patients pay for their hospital services in the absence of medical need. Additionally, private obstetric patients should not be able to attend the public hospital clinic; rather, they must attend the clinic at the hospital.

A further study could investigate how public hospitals currently manage the interface between private and publicly funded maternity services, particularly in terms of access, resource allocation, and clarity of service boundaries. Further inquiry might also explore the ethical and policy implications of publicly subsidised care being extended to private obstetric patients, and how this affects equity within maternity services.

#### 11.1.5 Policy Alignment with Legislative Intent

This research highlights how the implementation of the midwifery profession has deviated from the original intent of the Act, which sought to prioritise primary care and support midwifery autonomy. The findings call for policymakers to reinforce the legislative principles by ensuring that funding, guidelines, and institutional support genuinely empower midwives to work autonomously and within the scope of the partnership model. Social and health policy research needs to include a critical analysis of the Nurses Amendment Act, 1990 to inform the basis for examining how the legislation supports or undermines midwifery autonomy in practice. Such an analysis would explore the extent to which the Act protects the midwifery scope or inadvertently reinforces medical dominance through vague or conflicting provisions. Research could interrogate whether the regulatory mechanisms and language within

the Act reflect genuine support for midwife-led care or maintain a hierarchical structure that privileges medical authority. This line of inquiry would benefit from a socio-legal approach, analysing both the text of the legislation and how it is interpreted and enacted in practice by regulatory bodies, health institutions, and policymakers.

## 11.2 Contribution and Strengths of this Research

Historical and contemporary insights are evident within this research as it traces the evolution of midwifery in New Zealand, connecting historical developments, such as the passing of the Act, with contemporary practices. This historical perspective enriches understanding of the profession's trajectory and contextualises the current challenges.

Incorporating the voices of midwives and consumers who have continued to work within the landscape of maternity services since before the Act was implemented offers a unique perspective which has previously not been explored. Additionally, this research has identified how legislation, funding decisions, and Ministry of Health policies have tempered the midwifery profession and maternity services for women in New Zealand. This research contributes to understanding how external factors influence midwives' autonomy and current maternity experiences. The study further contributes to global discussions about the value of partnership-based care by exploring how the model has been developed alongside consumers in New Zealand. Finally, the study has identified and recommended a programme of future research.

## 11.3 Research Limitations

Limitations are recognised within the constraints of historic and archival documents. The study has relied on historical records and artefacts which may have had limitations in terms of completeness or availability. Some critical historical data or individuals' perspectives have been inaccessible and lost over time. Additionally, like all research, the study was conducted within certain time and resource limitations.

There were challenges in addressing intergenerational shifts. While the study makes generalisations towards the intergenerational differences in consumer expectations and midwifery practice, the underlying social, economic, or cultural factors driving

these changes were considered from the perspective of these participants. Therefore, they may not accurately represent the health care consumers' opinions of today.

### 11.3.1 Final Personal Reflection

I began this research curious about why. Why, in a system supposedly founded in partnership, did midwifery practice often feel so medicalised, and far away from the with-woman model I had experienced during my own pregnancies and in my own practice? I had not set out in this research to learn about myself; however, through this process I became a storyteller. I then realised I was not simply telling 'stories'. The participants entrusted me with their powerful narratives which were co-created stories of women that have long been waiting to be heard.

### 11.4 Conclusion

This thesis has foregrounded the voices of midwives and consumers who have long resisted the institutional subjugation of midwifery. Through their narratives what emerges is a deep commitment to re-centring childbirth as a woman-centred experience and reclaiming midwifery core principles. Across the findings participants described the ways in which dominant institutional powers, particularly the hospital system and the Ministry of Health as the central funding body, have limited midwifery professional autonomy. These constraints were not merely administrative or logistical but deeply ideological, reflecting a broader struggle over authority in childbirth and financial motivations. Midwives have been structurally constrained, subordinated, surveilled, and rendered economically invisible within systems that continue to privilege the biomedical model and prioritise technology.

What has become evident is the deeply embedded dominant medical model is constructed with the practitioner as the 'all-knowing' authority who intervenes to 'take the pain away' and, ultimately, 'delivers' the baby. This positions the medical model at the centre, reinforcing a narrative of control and the hero. In contrast, midwifery is grounded in the philosophy of 'attending' birth, supporting the physiological process rather than interference. This distinction was captured in Bronwen's statement, "*How dare you impinge on my practice? How dare you impinge on this woman's ability to do what she wants around giving birth to her baby*".

The testimonies revealed that midwives' work has been systematically undervalued, both in monetary terms and the broader social aspects of culture that continue dominant medicalisation. As a profession historically grounded in a partnership model and women-centred care, midwifery has persistently been othered. While the Nurses Amendment Act, 1990 granted legal recognition, participants described a disconnect between policy intent and the reality. Autonomy was granted in principle but has been thwarted in implementation, as the Ministry chronically ignored financial obligations to reimbursements, and enacted institutional gatekeeping and professional hierarchies, to maintain midwives in a position of structural subordination.

This thesis has interpreted the marginalisation of midwifery not as a failure of individual adaptation or compliance, but as a systemic intent to disempower. The 'othering' across the findings chapters speak to how midwives were symbolically and materially excluded from the dominant professional hierarchies. Traditional midwifery knowledge has been sidelined, its presence scrutinised, and its value diminished. However, these participants, undeterred, protected themselves and each other in a literal fortification in partnership, Jackie stated, "*we used to go everywhere and in the faculty with our arms linked*". Karen said, "they couldn't sack 12 of us". Bronwen mentioned "*the first thing they tried to do was separate us. And I said, 'well, I'm not talking unless she's here'. I need a witness to what's happening*". Even when being interviewed for this research, in two separate instances people created safe groups from a potential hazard, a situation they did not know what they were walking into.

Tangible elements of primary maternity care, such as statistical and empirical evidence identifying beneficial birth outcomes, and traditional midwifery skills like palpation to estimate foetal weight, are often undervalued within mainstream practice. Instead, clinical decision-making is frequently guided by intangible or invisible factors, including the rationale of 'just in case' that privileges ultrasound scans, routine applications of IV lines or continuous CTG, in the absence of clinical indications. The overarching fear of litigation or reputational harm influences a defensive practice which undermines midwifery autonomy, displaces evidence-based practice, and favours risk-averse interventions that are not always medically warranted.

What resonates most powerfully across the data is a deep frustration with the current structures and a profound sense of purpose and strength for continuing their work. Participants' resistance was not born of antagonism, but of conviction; a belief in women, in birth, and in the transformative potential of empowering birth experiences. The 'magic' of birth, as it was described, is not a nostalgic ideal but a testimony to the notion what midwifery services can offer. These incredible women were change agents; not victims, but heroines and survivors of a system that sought constantly to obstruct and sabotage their worthy project.

As this thesis concludes, it is evident that the reclamation of midwifery is an ongoing struggle, an unfinished revolution. To truly honour the legislative intent of the Act, and the dedication of the profession's pioneers, a structural realignment is required: one that prioritises physiological birth, recognises the value of care work, and dismantles the mechanisms of control that continue to delimit midwifery practice. Only then can midwifery be repositioned—not as a profession granted conditional legitimacy, but as a vital and autonomous contributor to the health and well-being of families and communities across New Zealand.

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# Appendices

## Appendix A Ethics Approval



### Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology  
D-88, Private Bag 92006, Auckland 1142, NZ  
T: +64 9 921 9999 ext. 8316  
E: [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz)  
[www.aut.ac.nz/researchethics](http://www.aut.ac.nz/researchethics)

15 December 2022

Susan Crowther  
Faculty of Health and Environmental Sciences

Dear Susan

Re Ethics Application: **22/360 Birth of a profession: A narrative inquiry of key informant oral histories into the shaping of midwifery in New Zealand, from 1990 to the present day.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 15 December 2025.

#### Standard Conditions of Approval

1. The research is to be undertaken in accordance with the [Auckland University of Technology Code of Conduct for Research](#) and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

Please quote the application number and title on all future correspondence related to this project.

For any enquiries please contact [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz). The forms mentioned above are available online through <http://www.aut.ac.nz/research/researchethics>

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat  
Auckland University of Technology Ethics Committee

Cc: [eriphannon@gmail.com](mailto:eriphannon@gmail.com); [EHanlon@adhb.govt.nz](mailto:EHanlon@adhb.govt.nz); [andrea.gilkison@aut.ac.nz](mailto:andrea.gilkison@aut.ac.nz); Charmaine Bright

## Appendix B Participant Information Sheet Approved



### Participant Information Sheet

#### Date Information Sheet Produced:

14 November 2022

#### Project Title

Birth of a profession: A narrative inquiry of key informant oral histories into the shaping of midwifery in New Zealand, from 1990 to the present day.

#### An Invitation

We invite you to be part of this research project which. Our names are Susan Crowther, Professor of Midwifery at AUT, Andrea Gilkison, Associate Professor of Midwifery at AUT, Charmaine Bright, Senior Lecturer in Psychology and Neuroscience at AUT and (Researcher) Erin Hanlon, RM, MPH, PhD Candidate

#### What is the purpose of this research?

In 1990 New Zealand maternity services underwent a major health reform. The Nurses Amendment Act implemented a midwifery model to improve service delivery for women and at the same time, it legitimised the midwifery profession locally. It is still the model of care today, 30+ years later. At the time, 'The Act' was revolutionary in that the LMC model established continuity of care and allowed women to choose their birthplace from either home, a primary birthing facility or hospital.

This research will document how the individuals responsible for present day midwifery fought for and won independent practice. By collecting the stories from those individuals to understand how the New Zealand midwifery profession has developed over time.

The findings of this research may be used for academic publications and presentations.

#### How was I identified and why am I being invited to participate in this research?

You are being invited to participate in this research because you are known by your midwifery colleagues to have been involved in childbirth activism or domiciliary midwifery before midwives in New Zealand were practicing autonomously. We are seeking between 12 - 20 participants to take part in sharing their experiences about the time just before The Nurses Amendment Act 1990 was passed and throughout your career.

#### How do I agree to participate in this research?

To confirm your participation in the study, you can contact the Researcher, Erin via email ([EHanlon@adhb.govt.nz](mailto:EHanlon@adhb.govt.nz)) indicating you would like more information or you would like to participate in the research. You are welcome to ask any questions you may have.

Once you have contacted the Researcher you will be emailed a consent form which you can read and then the Researcher will negotiate times, dates, locations for the interview.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

#### What will happen in this research?

You will have been emailed the consent form and if you have agreed to participate in the research, interviews will be planned for either in-person or via Zoom. You will have the opportunity to choose the interview location that suits you, from a quiet public space such as a library or in your home. The interview will take approximately 60 - 90 minutes of your time. The duration is dependent on how much you would like to share on the day. Before the interview begins you will be given the opportunity to ask any questions you may have regarding the research.

Interviews will be digitally audio-recorded and then transcribed using a transcriber software programme. Once the information has been recorded electronically we will destroy the recordings.

Questions you will be asked will begin with your association with midwifery or activism. For example, you may be asked about what inspired you to become involved in activism or became involved in midwifery in the late 1980s. Other questions may focus on your career progression in terms of what other professional roles you held clinically or in education or the governance.

After the interviews are transcribed, you will be asked to review and edit the transcripts for accuracy and amend your story as you would like and then return your transcript back to the Researcher. If the Researcher has questions or would like some clarification, you may be contacted via email a further time. At the conclusion of the research, should the researcher present material resulting from this study at a local conference, you will be notified if you would like.

The research team may ask you if you are able to send along the information sheet and study material to someone you know that was also involved in childbirth activism in the late 1980s. You are welcome to ask questions about this and if you are not interested in assisting with recruitment, that will not disadvantage you in any way.

**What are the discomforts and risks?**

It is unlikely that you will experience any risks or discomforts as a part of this research. In our experience many people feel rewarded in sharing their story and experiences. However, we are aware that not everyone's experiences are the same and that by revisiting some historical events in your career may be difficult. The Researcher will regularly pause to check-in to make sure you feel comfortable and supported. If at any point you feel distressed or uncomfortable, you may indicate that and you are free to move on and/or you may decline to answer specific questions.

You will be identifiable in this research as having been involved with constructing the profession of midwifery with in New Zealand. As such, there may be aspects of your experience that is shared which may be of a contentious nature. However, the final reporting will not attributed specific accounts to you and events that you share will be as part of the group collective of the experiences, instead of a specific person. In that way, we hope to keep aspects you share removed from your specific story.

Additionally, you will have the opportunity to review and edit your transcripts as you wish, before sending back to the Researcher.

**How will these discomforts and risks be alleviated?**

The interviews dates, times and places will be negotiated and will be held in a private and safe space to ensure that it is culturally safe and appropriate so that stories can be heard. The interviews will be led by Erin who is experienced in research interviews and taking personal histories.

If you need further support after the interview, you are welcome to further discuss this with the Researcher or Supervisors.

**What are the benefits?**

This research is focused on collecting the stories from a select group of individuals, including yourself, who were responsible for creating the internationally regarded midwifery model within New Zealand. Aside from capturing these experiences for posterity, your story will provide insights into how this independent profession came into law and how the midwifery profession has been shaped over the last 30 years. The research will be presented at conferences, and published in academic journals.

**How will my privacy be protected?**

The reasons for this research are to celebrate your work which contribution in creating and developing the midwifery profession that is the model for practice in New Zealand today. Your name will be used in the final reporting and your identity will not be kept private. However, you will have the opportunity to review and modify the transcripts from your interview. Your contact details will be stored in a secured location and only the AUT research team will have access. You will have the ability to redact aspects of your story as you would like. Additionally, the final reporting will not be attributed to individuals; rather the themes reported will be not linked directly to you.

**What are the costs of participating in this research?**

The cost to you is your time. Interviews are anticipated to last anywhere from 60 - 90 minutes, or longer if you have more to share. If the interview extends over the 60 minute the Researcher will check in regularly (every 15 - 30 min) with you to ask if you would prefer to continue or wrap up.

To thank you for your time, you will receive a \$25 voucher as an appreciation to your contribution to the research study.

**What opportunity do I have to consider this invitation?**

You will have around six weeks to consider participating. After the initial email, if a response has not been received by the Researcher within two-weeks, a single follow-up email will be sent. Should a response not be received within four weeks from the second email then you will not be emailed again by the Researcher. It will be presumed that you are

not interested in participating and your email address will be deleted from the Researcher's email folders. Alternatively, if you know you do not wish to participate, you are welcome to email Erin the Researcher anytime so that you are not contacted further.

**Will I receive feedback on the results of this research?**

You will receive the transcript of the interview for editing and will return this to the Researcher after two weeks from receiving it. If you would like to receive a summary of findings, you can indicate this on the consent form, and you will be emailed that once the research has concluded. Additionally, if the results from this research are planning to be presented at a conference, you will be notified.

**What do I do if I have concerns about this research?**

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Professor Susan Crowther, [susan.crowther@aut.ac.nz](mailto:susan.crowther@aut.ac.nz) or 09 921 9999 ext 7912

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz), (+649) 921 9999 ext 6038.

**Whom do I contact for further information about this research?**

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

***Researcher Contact Details:***

Ms Erin Hanlon, [EHanlon@adhb.govt.nz](mailto:EHanlon@adhb.govt.nz), 09 307 4949 x 23852

***Project Supervisor Contact Details:***

Professor Susan Crowther, [susan.crowther@aut.ac.nz](mailto:susan.crowther@aut.ac.nz) or 09 921 9999 ext 7912

Approved by the Auckland University of Technology Ethics Committee on 12 December 2022, AUTEC Reference number 22/360.

## Appendix C Ethics Consent Form



### Consent Form

**Project title:** *Birth of a profession: A narrative inquiry into the shaping of midwifery in New Zealand*

**Project Supervisor:** Professor Susan Crowther

**Researcher:** Ms Erin Hanlon

- I have read and understood the information provided about this research project in the Information Sheet dated 14 November 2022.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- I understand that I will be given the opportunity to modify my transcripts.
- I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- I agree to take part in this research.
- I agree to my identity being listed as a participant in publications: Yes  No
- I agree that transcripts may be used in future research: Yes  No
- I wish to receive a summary of the research findings (please tick one): Yes  No

Participant's signature:

.....

Participant's name:

.....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEC Reference number 22/360**

## Appendix D Ethics Interview Schedule



### Interview Schedule

Project title: **Birth of a profession: A narrative inquiry into the shaping of midwifery in New Zealand**

Project Supervisor: Professor Susan Crowther

Researcher: Ms Erin Hanlon

Midwife/Women's Health (WH) Activist participants:

Questions re: Before 'The Act' passed

1. What inspired you to become involved with the childbirth movement in the late 1980's?
2. What was your role?
3. What did it mean for you when 'The Act' was passed?
4. What changed for you, personally and professionally?

Questions re: After 1990

Midwife Participant / Re: language in 'The Act' (continuity of care, payment scheme, reduce medicalization)

1. What did being a midwife mean to you
2. What was your professional role? i.e. practice/developing the College
3. Did that change over time and why?
4. What was the progression like going from practice to a role (in education, governance, etc.)
5. Can you tell me about any professional challenges you faced?
6. Looking back, what was the best experience

WH Activist Participant

1. How did your professional role change?
2. What changes did you experience after 'The Act' was implemented?
3. How do you perceive the changes in culture over the last 30 years?

Policy maker Participants

1. How did you become involved in the plight of maternity care in the late 1980s?
2. What was the mood like in government at that time? In terms of 'women's issues'
3. What was it like for you to be involved in major changes in women's health?

*Approved by the Auckland University of Technology Ethics Committee on 15 December 2022 AUTEK  
Reference number AUTEK 22/360*

## Appendix E Initial Story Map Grid

Chapter 8 The Early Years	Chapter 9 Learning, Unlearning and Relearning; A Practice Shift	Chapter 10 Institutional 'Othering' of Independent Midwives	Chapter 11 Current state of midwifery-led care
<p>8.1 Standard of Care This chapter presents the conditions or context prior to midwives' autonomy. Presented are experiences of domiciliary midwives' work being financially undervalued. DMs supported women's choices of interference and who could attend - at home.</p>	<p>9.1 Experiences of midwives unlearning the training/fear and education within the hospital institution and their accounts of relearning how to become domiciliary (or homebirth) midwives</p>	<p>10.1 Midwives experiences of 'othering' at the hands of The Ministry 10.1.1 Abuse of Power; The Ministry Withholding funding 10.1.2 The Ministry Continues to Default on Midwives' Pay</p>	<p>11.1.1 Midwives adopted strategies to maximise pay: -increase their caseload. (impact from increased caseload / partnership?/ informed consent?) -fragment (continuity model strained) services/farm out postnatal/focusing on one aspect of service -leave midwifery profession</p>
<p>8.2 Domiciliary midwives pay The Pay is a thread that I want to be bringing through all the chapters, as it is a core component to the undervaluing of the profession</p>	<p>9.2 Agitating for change. Outlines actions of participants to change within wider society. Public education, antenatal classes 9.2.1 Dismantling the system / The Act Retelling of where participants were when the Act passed.</p>	<p>10.2 The impact of the othering/financial withholding; 10.2.1 On midwives as individuals 10.2.2 On the profession as a whole 10.2.3 Disillusionment; Midwives and their College</p>	<p>11.2 The WHY (to keep going despite adversity); what midwifery gave you (despite the pay, why did these midwives keep going? They share their experiences)</p>

Chapter 8 The Early Years	Chapter 9 Learning, Unlearning and Relearning; A Practice Shift	Chapter 10 Institutional 'Othering' of Independent Midwives	Chapter 11 Current state of midwifery-led care
8.3 Relationships/Partnership (professional relationship) whakawhanaunga; Home birth GPs, midwives, consumers	9.3 Professionalising midwifery; A new standard of (midwife-led) care 9.3.1 Redefining the scope of practice 9.3.2 Midwives versus med-wives; A midwife is a midwife, is a midwife	10.3 Hospitals 'Othering' Midwives 10.3.1 Hospital Adversarial Treatment of Midwives; controlled autonomy	11.3 Supportive factors; midwives protecting themselves and others (examples of what midwives have done to support themselves, and others to stay in LMC practice)
8.4 Consumer experience; Their 'why.' Glenys: <i>We were trying to elevate midwives as the guardians of natural birth.</i>	9.4 All the roles midwives hold (or a different title, perhaps) (would a Lawyer do this? – I'm trying to capture the essence of the 'invisible' and closely related 'domestic' work that women do that goes unseen and undervalued. This section encapsulates the over and above care that midwifery provides within the community. A lot of the 'extra' work goes unnoticed, some women were undocumented and therefore more vulnerable. Midwives get into these houses and provide care when the hospitals turn these patients away (or charge them)	10.4 The Ministry perspective This section outlines the MOH view, at the time of the research. The Ministry's interview discourse evidenced strong focus on 'accountability measures' to be imposed on LMC midwives to curb what is considered by them as 'poor' behaviour. Zero accountability on their part to pay midwives for services rendered (during covid) or to negotiate with The College. Further, when I asked how the MOH supports physiological birth, the response was redirected to accountability measures of midwives. (Ugh!)	11.4 Supporting normal childbirth over the whole-time frame (quotes outlining how midwives have done this, and consumers discuss their daughters' / childbirth education. Not all quotes are current.)

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**Chapter 8**  
**The Early Years**

**Chapter 9**  
**Learning, Unlearning and**  
**Relearning; A Practice Shift**

**Chapter 10**  
**Institutional 'Othering' of**  
**Independent Midwives**

**Chapter 11**  
**Current state of midwifery-led care**

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9.5 Direct-Entry Midwifery;  
Educating midwives

11.5 Practice shift 360; DM back in  
hospital / Modern maternity = 'med-  
ernity'

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## Final Story Map Grid

*Thesis Title: New Zealand Midwifery's Journey from Suppression to Autonomy, A Narrative Inquiry*

Categorical - content

### Findings chapter headings / Narrative categories

Narrative Category- The Early Years	Narrative Category: Learning, Unlearning and Relearning: A Practice Shift	The 'othering' of independent midwives	Modern maternity, "modern maternity"	Spread out and stick together
Chapter 6	Chapter 7	Chapter 8	Chapter 9	Chapter 10
<b>Research Questions</b>				
<p>What aspirations did these participants have for maternity care, and how did they envision their role in shaping its transformation?</p>	<p>How did participants navigate their professional relationships with other maternity care providers, and what influenced these interactions?</p>	<p>How did the formal professionalisation of midwifery impact the financial sustainability and autonomy of independent midwives following the passing of The Act?</p>	<p>What challenges did midwives face in securing recognition and legitimacy as primary maternity care providers within the healthcare system?</p>	<p>How have participants sustained their commitment to physiological birth and midwifery autonomy over time, despite systemic constraints and professional marginalisation?</p>
<p>How did participants experience the maternity system prior to The Nurses Amendment Act 1990, what challenges did they encounter?</p>				

<i>Chapter sub-headings</i>				
Standards of practice	Experiences of unlearning, and relearning	Historical precedence of othering	Defensive practice strategies	Midwives as guardians: Advocating for each other
Domiciliary midwives and home births	Agitating for change: The collective organising	The NZMA's campaign of defamation	<u>Sub</u> : Autonomy constrained	Midwives advocating in education
Relationships: GPs, Domiciliary Midwives and Consumers	Dismantling the system: The rock breakers	<u>Sub</u> : The role of media in the discrediting of midwives <u>Sub</u> : Maternity Benefit Tribunal, new prime minister and payment restructure	Working the model to make it work: Financial implications of othering	Consumer dedication to partnership
Relationships: Consumers and Domiciliary Midwives	The dam breaks: A community flooded by midwives	The Ministry of Health's cultural toxicity and the impact of "othering" on midwives	Modern constraints in midwifery education	Collectively supporting normal birth
	Midwives versus med-wives: 'A midwife is a midwife, is a midwife'	The Ministry of Health's cultural toxicity and the impact of "othering" on midwives	Partnership in distress: the Millennial mother	Sustaining the flame: Continued devotion to midwifery
	The invisible work of midwives	<u>Sub</u> : The Ministry's Perspective in 2023 <u>Sub</u> : Deceitful othering; The Ministry fails to pay	Midwives full circle: Institutional expectations	
	Direct-entry midwifery: Educating midwives	Hospital institution othering of independent midwives	The toll on the profession	
		How othering controls professional autonomy		

### Chapter Meta Narratives

<p>Patriarchy - presents for women: At home = 24/7 unpaid work</p> <p>In Hospital = 14-day rest from: children, home duties</p>	<p>Patriarchy - Participants fight stemmed from / Institution vs Home</p> <p>Institution- built structure, protocol, embedded surveillance, prioritise individualism / male-dominated capitalistic / religion - ('I can do it myself') (I did this ALL by myself)</p>	<p>Patriarchy - MoH Exclusion of COM, women/consumers / MOH use external professional 'consumer'</p> <p>Judi Strid @ conference (1995); med-wives excl. consumer</p> <p>Accountability measures (not accountable for their contribution to break down in model; or increasing medicalisation in birth)</p>	<p>Patriarchy - Petal-less flower chipping away at autonomy:</p> <p>Continuously increasing expectations (rules not guidelines)</p> <p>Surveillance/ monitoring = threats of potential 'danger' 'just in case' / tangible vs intangible</p>	<p><i>'It wasn't just about me'</i> BP</p>
<p>Hospital - takes labour pain away</p> <p>Pain often not taken seriously at any other time of her life</p>	<p>Home - women's sphere, community (It wasn't just about me -Bronwen) / (Jackie - arms linked w Liz x2 / (Karen - 12 midwives, Home Birth Association: food, nappies, gift to midwives (Andrea, Joy, Glenys)</p>		<p>Social and conforming to pressures - leads to: Increase dependency on Technology Busywork vs traditional midwifery skill (too busy to: Reflect, question, notice, unlearn, relearn, challenge, Strike (against MOH) Midwives- unpaid work</p>	
<p>Hospital - takes baby away for mom to rest</p>			<p>Fragment model (maximise pay &amp; get all work done)</p>	
<p>Upsets bond / breastfeeding</p>			<p>Manipulate / adaptive strategies</p>	

## Appendix F Professor Bonham "At Risk"

Postgraduate School of Obstetrics and Gynaecology  
University of Auckland

3/80

### IDENTIFYING THE "AT RISK" PREGNANCY

by Dennis G. Bonham

*Bonham*

With the available facilities in Oceania ranging from the highly sophisticated units in large centres to home confinement in villages far from specialist services it is fundamental to proper perinatal care (for both mother and baby) that risk factors be carefully evaluated for every pregnancy. Only then is it possible to advise the type of care and place of confinement preferable for the mother and fetus in question. Most parents, aiming for a small family of alert, healthy children will accept such advice; others may reject conventional advice. In such cases the doctor may wish that he had free choice of patient just as the patient has free choice of doctor but in country areas this may not be possible and a compromise may have to be effected.

The concept of a range of risk began with studies of maternal mortality, when it was shown that the confinement of older, highly parous mothers, with or without other unfavourable warnings in their history, away from specialist obstetric, anaesthetic, paediatric and blood transfusion facilities was associated with a higher than expected risk of maternal death.

More recently epidemiological factors in the mother like her age, parity, height, social class, smoking habits and past reproductive performance have been shown to be of great importance in neonatal outcome. In general risk factors for maternal outcome are similar to risk factors for neonatal outcome.

Having prepared a scale of risk there will be some women obviously at the high risk end and some at the low risk end where all would agree. Between these extremes the risk is relative and interpretation is more subjective when considered by a group of assessors.

The decision of how the risk is to be interpreted in terms of purveyor of prenatal care and place of confinement must, in this part of the world, depend on the local services available, transport facilities, the effect of natural hazards on roads etc, more than on the desires of the doctor or ease of relatives visiting in the puerperium. In general it is easier, safer and more comfortable for mother and baby if they are transported to optimum facilities prior to labour rather than in labour or after delivery.

Obstetric risk assessment is performed (i) early in pregnancy (or even prior to pregnancy) and updated (ii) during pregnancy, (iii) at the onset of or during labour and (iv) postpartum.

SELECTION EARLY IN PREGNANCY involves consideration of epidemiological characteristics; age, parity, height, social class or educational standard, smoking habits, obstetric history and certainty of dates in the current pregnancy.

Maternal age significantly affects maternal and perinatal outcome. Both very young and older mothers are at increased risk. After 35 years (30 in primigravidae), risks are increased appreciably for physical reasons while the greater risks in younger mothers probably relate to fragmented care rather than physical limitations.

Parity affects both maternal and perinatal outcome in a similar but separate way to maternal age. The second pregnancy is by far the safest with the third and fourth safer than the first.

Considering age and parity together (figure 1) the perinatal risks for each age-parity group are shown together with the percentage of the reproductive population may be found in each statistical "cell". By far the safest age-parity combinations are second pregnancies from 20-34 years, these make up about 30 per cent of the reproductive population in New Zealand. The next safest groups include third and fourth babies in women under 35 (over 35 maternal risks are rising).

Maternal height under 155cm indicates increased risk as does gross obesity.

Social class or educational level is closely and significantly related to maternal and fetal outcome and it now appears that social and educational criteria are of greater importance than race alone. An important association of social or educational level is the incidence of low birth weight infants. The incidence of low birth weight infants doubles across the social class scale. In general terms the lower 20 per cent of the population should be treated specially because of the greater risks. Maternal risks are high in unmarried mothers and non-Europeans in New Zealand

Smoking in pregnancy is associated with perinatal death, premature labour and low birth weight through mechanisms not yet clear. Pregnancy and particularly pre-pregnancy is an important time to discourage smoking. In the United States alcohol consumption has become a new risk factor as yet unsubstantiated in New Zealand.

#### OBSTETRIC HISTORY

There are important associations from history for fetal outcome.

#### Previous Miscarriages (or ectopic pregnancies)

For the population previous miscarriages increase the perinatal risk by 50 per cent. The nullipara, with one or more early unsuccessful pregnancies has a 25 per cent greater risk. Previous late pregnancy terminations (after 12 weeks) may also prove to increase risk.

#### Previous Low Birth Weight Infant

A previous low birth weight live birth doubles the risk to subsequent babies even if the first infant survives.

#### Previous Perinatal Death

A previous perinatal death (stillbirth or neonatal death) increases the risk to subsequent babies by at least 2.5 times and in some instances up to 6 times. Such patients should always be under specialist supervision.

Old nutritional / Socio-economic factors

#### Previous Pre-eclampsia, Antepartum Haemorrhage or Caesarean Section

A history of any of these abnormalities raises the risk to any subsequent infant. Even pre-eclampsia in the first pregnancy increases the risk in the second by 39 per cent.

Caesarean sections in the past confer a particularly high fetal risk apart from the obvious maternal danger. The subsequent fetal risk is more than doubled. Apart from recurrent conditions the fetal risk is increased because of iatrogenic immaturity. After a previous caesarean section the uterus often appears higher in the abdomen in the next pregnancy and thus leads to over-estimation of maturity. *iatrogenic = doctor/drug induced*

So far as maternal risk is concerned, past problems particularly previous caesarean sections, third stage complications and recurrent pre-eclampsia are well accepted indications of risk.

All of the above factors can be determined when the history is taken at the first prenatal visit. Findings of heart disease, diabetes, hypertension, renal disease, asthma, epilepsy or blood group, antibodies and the reliability of the menstrual history at booking examination assist in the classification of the mother into a high or low risk category and should now permit a reasonable decision to be made on who should accept the responsibility for outcome, family doctor or specialist. In some cases early specialist referral for advice on the risk issue is worthwhile.

{ The importance of an early check on maturity by a specialist where the dates are uncertain cannot be over-emphasised. This requirement is not discharged merely by an ultrasound consultation!

#### CHANGE OF STATUS DURING PREGNANCY

Having made appropriate selection at booking the practitioner then has to seek high risk indicators that arise during pregnancy. Such indicators are well covered in conventional teaching and here we only emphasise those of particular importance.

Before 28 weeks uterine bleeding and infections are risk indicators. Rubella, toxoplasmosis and probably other infections may affect the fetus. With rubella immune status reaching high levels of over 90 per cent for the time being at least the risk is now rare. Any uterine bleeding in pregnancy appears to carry an ultimate fetal hazard.

At 28 weeks the practitioner has a very specific task - the identification of multiple pregnancy. Multiple pregnancies increases maternal and fetal risks some 5-6 times and all must be diagnosed by 28 weeks. We should always ask ourselves at 28 weeks; has she twins? If in any doubt confirmation by radiology or ultrasound is indicated. All multiple pregnancies must be under the care of a specialist by 28-30 weeks.

As pregnancy proceeds beyond 28 weeks we seek evidence of pre-eclampsia, antepartum haemorrhage and polyhydramnios. Fundal height and girth charts give the first clue to impaired intrauterine growth. Malpresentations are usually evident but lack of a clearly defined fetal head on palpation should raise the question of anencephalus.

The final pregnancy risk group comprises the big baby, posterior position, prolonged pregnancy syndrome. One's own clinical estimation of fetal size is an important clinical skill. Early confirmation of the dates will have set the standard for prolonged pregnancy. The average obstetric practitioner with a relatively normal practice will save more lives in the big baby, prolonged pregnancy, posterior position, intrauterine anoxia (in labour) clinical syndrome than in any other part of his obstetric practice. The sad problems of meconium inhalation should now be regarded as preventable.

#### ONSET OF LABOUR

At the onset of labour risk indicators are again discernable.

#### Premature "spontaneous" labour

All practitioners, not only obstetric ones, should be alert for the onset of premature or "threatened" premature labour before 35-36 weeks, it is one of the most serious risk factors from the fetal angle. This applies in accident and emergency departments, medical, surgical and psychiatric wards. Sit with the patient and if the uterus is contracting send mother forthwith to a hospital with full facilities. If the journey will take an appreciable time an infusion of a  $\beta$ -mimetic agent should be used to inhibit labour during transfer and a first corticosteroid injection considered. The approved treatment plan for premature labour should be known beforehand by local communication with the unit concerned.

#### Labour starts with rupture of membranes

When the membranes rupture after 36 weeks but before contractions start, labour is likely to be either quick and easy or long and difficult. The easy labour is recognised by contractions starting within six hours of membrane rupture, these being progressive in amplitude and duration and associated with normal findings on vaginal examination. Trouble is anticipated if contractions do not start and progress within six hours or if the head is high, posterior and the cervix unfavourable, or obviously if there is already meconium in the liquor.

#### Bad start to labour

The experienced practitioner will have learnt to recognise the bad start to labour. Contractions are irregular, may be uncomfortable early, cause discomfort before they are palpable, and fail to progress in amplitude and duration; often the baby is large, the head high, occipito posterior and the pregnancy is past term. When the membranes rupture there is already meconium. Such patients should be moved before type II dips make it too late.

#### Artificial start to labour

When inducing labour (or performing an elective caesarean section) there are already risk indicators for which the procedure is being done. It is essential not to add to the risk with iatrogenic immaturity produced by delivering the baby "unexpectedly" early.

POSTPARTUM

Risk factors as determined should have resulted in appropriate delivery in almost all cases. In those rare cases where delivery occurs away from full services there may still be time and indications to move baby (and mother) to special neonatal expertise where low birth weight, prematurity, poor respiratory function or other problems including some malformations (oesophageal atresia, cardiac etc) are only noted after birth. Postpartum convulsions, disorders of coagulation and renal failure are rare indications for moving the mother.

With proper evaluation of risk the best care will be available to the mothers and babies in greatest need and the best use will be made of the range of services available. High technology must always be complemented by good human relations and above all by adequate explanation to the patient and her partner.

FIGURE 1

%	AGE - PARITY N.Z. 1972-73					
	PNM					
PARITY AGE	0	1	2	3	4	TOTAL
<20	6.6 20.0	2.3 18.3	0.2 20.9	0.01 71.4	0.002 -	9.1 19.7
20- <25	18.6 19.6	14.3 19.0	4.6 17.0	1.1 15.0	0.3 21.6	36.9 16.6
25- <30	8.9 21.2	12.3 10.8	8.1 15.0	3.1 15.3	1.9 22.4	34.3 15.5
30- <35	1.8 19.9	2.9 17.9	3.6 16.8	2.7 19.3	2.8 22.2	13.8 17.9
35- <39	0.5 31.3	0.6 18.6	0.8 15.9	0.9 18.7	1.8 29.9	4.5 24.1
40+	0.15 50.3	0.09 18.9	0.13 29.2	0.2 31.5	0.8 47.7	1.4 41.7
TOTAL	34.5 20.4	32.6 12.6	17.3 16.1	8.0 17.6	7.6 26.7	100 17.4

HIGH RISK PREGNANCY DETECTION

Pre-pregnancy or booking  
Pregnancy  
Labour  
Postpartum

MATERNAL AND FETAL RISK ASSOCIATES

Booking or Pre Conception

Age	Cardiovascular
Parity	Renal
Height	Diabetes
Social class	Blood group. Antibodies
Educational level	Asthma. Epilepsy etc.
Smoking	
Obstetric history	
Unsure dates	

RISK INDICATORS IN PREGNANCY

Pre 28w	Infections and bleeding
28w	Multiple pregnancy
Post 28w	Toxaemia, polyhydramnios antepartum haemorrhage
	Impaired growth
	Malpresentations
	Big baby, posterior position, prolonged pregnancy

RISK INDICATORS

ONSET OF LABOUR

Spontaneous

Premature labour <35 weeks  
Early rupture membranes  
Bad start - high head  
posterior position  
prolonged pregnancy  
meconium

Artificial

Beware  
iatrogenic  
immaturity

## Appendix G Helen Clark's Introduction NURSES AMENDMENT BILL: 9 NOV 1989

*Hansard - Stage: INTRODUCTION - 9 NOV 1989*

**NURSES AMENDMENT BILL : Introduction**

**Main speaker - Hon. HELEN CLARK**

**NURSES AMENDMENT BILL**

**Introduction**

Hon. HELEN CLARK (Minister of Health): I move, That the Nurses Amendment Bill be introduced. Although this Bill has only two clauses it has considerable significance for the delivery of childbirth services and the practice of midwifery. The Bill will enable a midwife to take responsibility for the care of a woman throughout her pregnancy, childbirth, and the postnatal period. At present, section 54 of the Nurses Act 1977 makes it an offence for a midwife to provide a service unless a medical practitioner has undertaken responsibility for the care of the client. At present, subsections (1) and (2) of section 54 of the principal Act have the effect of prohibiting a person from carrying out obstetric nursing if responsibility for the care of the patient is undertaken solely by a registered midwife. Such responsibility may be undertaken only by a medical practitioner. The effect of clause 2 is to allow a registered midwife to undertake sole responsibility for the care of the patient in such cases. This places a registered midwife in the same position as a medical practitioner for the purposes of section 54.

In recent years there has been a consistent message from various groups and organisations that childbirth is a natural process, and that a woman should be able to choose to have a midwife deliver her baby without the need for a woman also to be under the care of a medical practitioner. The New Zealand Planning Council noted that pressure has grown for childbirth to be seen as a natural process, whilst the women's health committee to the Board of Health saw the role of the midwife as central in providing choices and alternatives in the birth process. In 1987 Treasury was moved to comment on the maternity benefit schedule---whether it was the public or doctors who benefited from the restriction in section 54(1) of the 1977 Act.

Area health boards are exploring alternatives in the provision of maternity services. Some boards are developing innovative ways of delivering childbirth services that fully utilise the expertise and skill of midwives. This amendment will facilitate changes already planned by boards that wish to make services more flexible and consumer-orientated.

It is essential, in removing the restrictions on the practice of midwifery, that the safety of the woman and baby remain paramount. I am confident that such safety will be maintained, because registered midwives are competent to undertake the more independent role proposed. A midwife must successfully complete a recognised midwifery course before gaining registration as a midwife. Midwives are held accountable for safe professional practice through the Nursing Council of New Zealand.

Having a baby is not an illness. It is a normal physiological process that for generations was viewed as such. With the advent of medical technology there has been a trend towards treating pregnancy and labour as an illness. That has resulted in an increasing amount of medical intervention in the management of normal pregnancy, which has contributed to the erosion of the midwives' role and has proved to be both costly and, in many cases, inappropriate. Medical practitioners are trained to diagnose and treat people with illnesses and abnormalities. In pregnancy and childbirth their expertise is very necessary in high-risk, complicated, and abnormal cases.

The focus of a midwife's expertise, however, is low-risk, uncomplicated, and normal pregnancy and childbirth. The great majority of births in New Zealand---that is, 85 percent---are normal and do not as a matter of course require medical intervention. It is appropriate that midwives are able to provide a low-technology childbirth service to meet the needs of low-risk women. This amendment will give women the choice to access the services of either a medical practitioner or a midwife when available.

Midwives as professional people are committed to providing care of the highest quality. Midwives have national standards for midwifery practice, service, and education. The development of peer review systems that involve consumers is more evidence of the professionalism of our midwives. A midwife is educated to give the necessary supervision, care, and advice to women prior to, and during pregnancy, labour, and the postnatal period, to conduct deliveries on her own responsibility, and to care for new-born babies and for infants.

The care that a midwife is qualified to give includes detection of abnormal conditions in mother and child. A midwife is ultimately concerned with the healthy, well woman, and is skilled in assessment and referral to medical practitioners of women with complications. The midwife has an important role in the prevention of complications, and works to achieve that through education of the woman and her family, and of the wider community. She is qualified to work in any setting, be that home, hospital, or community.

A working-group was set up by the Department of Health to investigate safe options for low-risk pregnancy. The membership of that group includes a general practitioner, an obstetrician, midwives, and various consumer groups. The group has endorsed the removal of the restriction on midwifery practice. The members' comment on the proposed change was that they believed it would generally be very well received by their colleagues. Midwives will be working together with other health-care providers in the provision of childbirth care. In conclusion, the Bill will allow qualified midwives to take responsibility for the care of their clients. It will encourage better use of skilled health professionals. It acknowledges a woman's childbirth choices, makes the service more

## Appendix H Data Analysis Coding Example

### Reference 2 - 0.13% Coverage

BH:..doctors were leaving and another thing that was happening was that GP's didn't do/no longer did Obs [obstetrics], would either refer women to the team,

### Reference 3 - 0.38% Coverage

BH: at the hospital, or they refer them to a colleague and they had an arrangement with that colleague that he would return them to the original GP after the birth, the doctors didn't want to lose what was going to become two clients, so they didn't want woman shopping around independently and finding a GP who did provide maternity care, so they gate-kept to make sure that those women, post pregnancy and with their babies came back to them, it was all very strategic

### Reference 4 - 0.49% Coverage

BH:..there were fewer and fewer doctors by 1990, you can probably access the stats, In lots of areas there were very few doctors providing maternity care, so women were getting no continuity, they were going to the hospital teams, the antenatal hospital team, then labour and birth somebody else or often a variety of somebody else's -postnatally and the same for the women who were referred to a neighbouring doctor, who may go to their doctor for their early antenatal care, a different doctor for late pregnancy and the birth and then the hospital team would provide the postnatal care it was just ridiculous.

### Reference 5 - 0.26% Coverage

BH: Typically, up until very recently when women got pregnant they still went to their doctors for 'confirmation of pregnancy.' They do a urine sample and if it's if it's negative then the woman pays for that visit [laughs] cause it's not free yeah, it's crazy,

<Files\\Carolyn Young> - § 2 references coded

### Reference 1 - 1.55% Coverage

CY: the GP's were dedicated but I'm talking about the home birth GP's who offered care who were exceptionally giving of themselves and the quality of care and just as much as the vested interest of getting birth back to normal as what the midwives and the women had but not so much the GPs that just sort of built it into their practice and would come in at the actual moment of birth in the hospital setting, so yes it's a while since I've looked at how all that structure works but when it initially came out it was that if a GP was becoming the LMC for giving care then they were expected out of their funding to actually pay for the hospital midwifery care so I guess they were then literally taking a pay cut but as it was they walked in for an hour or even missed the birth completely and picked up the payment for the birth fee which was if you had only done a quarter of an hour's work, it was a very generous payment so it was, I think quite a lucrative business but I don't know from my experience way, way back of working in the hospital I don't know that all GPs enjoyed birth, they did it because it was part of looking after their practice and I think a lot of them were probably a bit fearful of birth too it's like get in and get out and so that for some of them it was an easy option to just pull out of providing care

## Appendix I Research Outputs From Thesis or Publication From Thesis

Conference Proceedings:

[Auckland University of Technology Postgraduate Research Symposium 2023 · Jun 12, 2023](#)

D6

Birth of a profession: A narrative inquiry into the shaping of New Zealand midwifery

Erin Hanlon (PhD) Faculty of Health & Environmental Sciences

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The intention of this presentation is to showcase the Narrative Inquiry methodology which has been used to explore the experiences of midwives who have worked in New Zealand since the 1990 when the contemporary maternity model was implemented. In-depth interviews took place across Aotearoa with 16 midwives and 5 consumers. Narrative Inquiry methodology has been utilised to perform interviews, transcribe, and analyse data. Participants shared their narratives of working clinically, in education, and within governance of the midwifery profession, and shared their narratives around how the profession of midwifery has evolved throughout the years. Using a framework sourced from Connelly & Clandinin (2006), this study references the concepts of temporality (time), place (location) and sociality (social conditions within New Zealand) in the analysis. Within narrative inquiry, temporality utilises timepoints such as past, present, and future to situate a story within the context of when events occurred with the vantage point of hindsight (Kim, 2015) to inform future events. These collated narratives capture historical perspectives of local midwifery over time, highlighting a shift in birthing culture which has led to changes in practice and how the profession has responded. Additionally, this korero will touch on how the ethical challenges were surmounted as the researcher proposed to directly contact participants and identify their names in the final write up.

**Keywords:** Narrative Inquiry; midwifery; The Nurses Amendment Act; research ethics; health reform

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Conference Proceedings:

Virtual International Day of the Midwife (VIDM) 5 May 2024

[‘Learning, Unlearning and Relearning: A Practice Shift’ Narrative Inquiry of core midwives’ experiences attending home births in New Zealand](#)

Virtual International Day of the Midwife 5 May 2024

## Erin Hanlon

**Session 05**

'Learning, Unlearning and Relearning: A Practice Shift'  
Narrative Inquiry of core midwives' experiences attending home births in New Zealand.

www.vidm.org  
#VIDM24

Speaker: [Erin Hanlon](#)

Facilitator: [Cecilia Jevitt](#) and [Akusmayra Ambarwati \(Shadow\)](#)

**Abstract:** Since 1990, New Zealand midwives have been privileged to elect to work within tertiary or primary health settings, employed, self-employed (case-loading), or a hybrid variation of both. However, despite the availability of midwife-led care, the local home birth rate has not substantially increased nor have medical interventions decreased, despite having a continuity of care. Narrative Inquiry methodology and methods were used to investigate the changes in the birthing culture in New Zealand from 1990 to today. The elements of temporality (time), sociality (social context), and place were borrowed from Connelly and Clandinin (2006) to collect and analyze stories from midwives and consumer participants nationally.

This presentation initially maps the history of midwives gaining autonomy in New Zealand, then explores the experiences of midwives who spoke about a transition in their clinical practice from working within a highly medicalised model across the spectrum to attend home births. These hospital-trained midwives shared their stories of how performing highly technological services in labour instilled fears around birth. Participants discussed that in order to become home birth midwives, they needed to unlearn and then relearn the skills required to attend women birthing at home. Using temporality and sociality contextualized their accounts, as participants shared their experiences of how they discovered what birth 'could be' with less interference, which separated them apart from the dominant medicalised culture surrounding birth. As they relayed their stories around their relearning, they expressed a collegiality with other practitioners, and supportive, trusted relationships with women.

24th International Labour and Birth Research Conference; University of Central Lancashire - Monday 15 - Wednesday 17 September 2025; Ribby Hall Village, Kirkham, Preston, PR4 2PR

**Voices of Change: How Consumer Advocacy Regained Midwifery Autonomy in New Zealand - Erin Hanlon**

16:20 - 16:35 Wednesday, 17th September 2025

Woodland 2

Presentation type Oral Presentation

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**6 Voices of Change: How Consumer Advocacy Regained Midwifery Autonomy in New Zealand**

Erin Hanlon, Susan Crowther, Charmaine Bright

Auckland University of Technology, Auckland, New Zealand

**Theme:** Incorporating service user or stakeholder voices

**Abstract**

This research employs a Narrative Inquiry methodology to examine the historical evolution of New Zealand's maternity system. The focus is the collaborative partnership between midwives and consumers, a relationship that culminated in the landmark 1990 Amendment Act, granting midwives autonomy. This pivotal shift was grounded in a shared vision of childbirth as a natural and empowering process, where women were actively involved in decision-making. A key component of this vision was home birth, which exemplifies the core principles of informed consent, prioritized women's voices, and ensured partnership; concepts that were integral to New Zealand even before the term 'continuity of care' was formally defined.

However, the system that was built on these principles of collaboration and consumer advocacy has faced significant challenges. Despite the promise of the 1990 reforms, structural and systemic barriers impeded the full realisation of a woman-centred maternity model. A lack of consistent funding and support from the Ministry of Health undermined midwives' ability to deliver care in line with their professional ethos.

This research presents participant's voices and their expressed concerns of the gradual shift towards a medicalised model, where intervention rates have soared. Consumers' voices, once pivotal in the maternity system, have grown quieter, overshadowed by institutional priorities and a service delivery landscape focused on 'risk' and intervention.

This original research using qualitative interview methods, captures the voices of the consumer and midwife participants who fought for the changes and share their concerns about the detrimental effects on the autonomy of midwives and the notable diminishing space made for consumer advocacy. The study offers transferable lessons for global regions seeking alternative maternity care models, underscoring the importance of sustaining the values of partnership and consumer-led reform in the face of evolving socio-economic and healthcare landscapes.



**Title:** Midwifery Resilience, Resistance, and the Enduring Commitment to Physiological Birth

**Abstract number:** ICM26-1777 / Oral Presentation

**Topic:** Strengthening Midwives' Associations

**Author(s):** Hanlon, Erin\*; Crowther, Susan; Bright, Charmaine; Auckland University of Technology

### **Background**

Midwifery is a living, evolving profession, shaped in relationship with women and their communities. This research offers a rare historical account of midwifery in New Zealand from the 1970s to 2023, capturing the narratives of domiciliary midwives and home birth women, whose activism and dedication were instrumental in achieving legislative change. Their work laid the foundation for New Zealand's current midwifery-led model of care.

### **Objectives**

To explore how these midwives sustained their commitment to physiological birth and professional autonomy across decades of systemic resistance, and how their legacy continues to shape midwifery practice today.

### **Methods**

Narrative inquiry was used to gather in-depth stories from midwives who practised across this transformative period. Ethical approval was granted by Auckland University of Technology Ethics Committee. Purposeful sampling focused on those with long-standing involvement in community-based, independent practice. Data were collected between March to July 2023 and analysed using an interpretive feminist framework.

### **Results**

Participants' narratives revealed unwavering dedication to midwifery values, sustained through collective resistance and deep belief in the power of natural birth. They navigated marginalisation within a medicalised system while mentoring new midwives and educating the public. Their reflections chronicled the passage of the Nurses Amendment Act (1990), and their pioneering role in shaping a model of care centred on relational continuity, community trust, and women's autonomy.

### **Conclusions**

This research honours the enduring contribution of a generation of midwives who not only changed the law but sustained the profession through passion, purpose, and solidarity. It documents a living history of resistance and renewal.

### **Key message**

- Midwifery thrives through community, courage, and historical consciousness.
- Intergenerational storytelling preserves midwifery knowledge and strengthens future practice.
- Policy change begins with practitioners who dare to imagine and deliver better.

- Strengthening midwifery globally requires recognition of the emotional, relational, and political work midwives perform every day.