

**What enables, safeguards and sustains midwives  
who provide labour care in primary units in  
Aotearoa-New Zealand**

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## **Abstract**

Primary maternity units hold an important place in contemporary Aotearoa-New Zealand and other high-income countries. Despite research evidence revealing that low-risk women have a greater chance of normal birth with fewer interventions and equal or improved outcomes for the woman and baby, the number of births in primary units in Aotearoa-New Zealand has declined. This study seeks to uncover what enables, safeguards and sustains midwives to provide labour care in stand-alone primary maternity units in Aotearoa-New Zealand; ‘what works’. Eleven midwives (hospital employed and self-employed) along with three obstetricians who provided a consultancy clinic at primary units were interviewed in this hermeneutic phenomenological study.

Findings show that midwives who provide labour care have an embedded mode of confidence grown from a firm belief in primary units as the space/place for low-risk women to labour and birth. The midwife’s confidence is regenerated through seeing normal labour and birth unfold in this space and by trusting the whole team. Paradoxically, midwives working in the primary unit need to uphold protection of normal birth while ensuring the woman and baby’s wellbeing is never compromised. Midwives are tasked with constantly thinking ahead, not to discourage the unfolding of normal, but to shed light on the things that might be problematic. There is a sense, by midwives, of ‘everyone’ in the primary unit being responsible; midwives speak out, guiding and protecting, supporting normal and recognising the not normal.

Good relatedness occurs with obstetric colleagues who consult in the primary unit. Support from colleagues in the secondary/tertiary region is essential to maintaining a midwife’s confidence in working in the primary unit. The work of the midwife promoting normal labour and birth in the primary unit needs to be upheld; what ‘works’ requires more than a midwife practising named technical skills. Midwives in primary units acquire an all-encompassing mode of confidence-as-conviction sustained by practising in this space. Having confidence and trust overrides fear and is reinforced by excellent relating within the primary unit team and the secondary/tertiary region in a manner that holds understanding and respect.

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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), 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.

Signed 

Dated: 26/5/17

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# **Chapter One: Introduction to the Study**

## **Context of Study**

In this Doctor of Health Science study, I seek to uncover what enables, safeguards and sustains midwives to provide labour care in primary units in Aotearoa-New Zealand. The country has a population of more than 4,700,000 people; with one quarter residing in the Auckland region. In terms of land mass, Aotearoa-New Zealand is relatively sparsely populated outside the major urban areas. Primary units are part of the maternity landscape in Aotearoa-New Zealand and are located in both urban and rural localities. Where available, these units provide an alternative birthplace for women who do not wish to labour in a secondary/tertiary (large) obstetric hospital, or use their private home. Primary units are a place and space for the process of normal labour and birth to unfold. In comparison, secondary and tertiary hospitals exist for technological processes and specialist personnel to cater for women at risk, complications, operative birth, and intensive care for neonates. Primary unit is the term for small low-technology units without access to caesarean birth theatres; internationally, other terms are used including freestanding or alongside midwifery-led units, birth centres, and birth clinics.

There are some 56 primary maternity units (freestanding small facilities) remaining within Aotearoa-New Zealand. Despite research evidence that shows safe outcomes for women and babies in primary units (Bailey, 2017; Brocklehurst et al., 2011; Christensen & Overgaard, 2017), the percentage of women giving birth in these units has declined in recent years (National Maternity Monitoring Group, 2016). A key impact of primary birthing units is that in an era where the caesarian section rate has risen in secondary/tertiary obstetric hospitals, the culture of normal birth is held in primary units which have minimal technology. Midwives who work in these units ‘hold’ the skill of facilitating labour care and working towards normal birth.

## **Research Question and Purpose**

The research question that propelled this study is:

**‘What enables, safeguards, and sustains midwives who provide labour care in primary units in Aotearoa-New Zealand?’**

The purpose of the study is to uncover insights that reveal enabling, safeguarding, and sustaining for midwives who provide labour care in primary units. The words ‘enable’, ‘safeguard’ and ‘sustain’ are selected to seek understanding of how midwives work in primary units providing labour care in a holistic way. The trio of words arose from my understanding that ‘safety’ is a key determinant of the viability of birthing units, yet to look at safety alone would not be enough. There also needs to be understanding of what ‘enables’ midwives to provide safe labour care, and what ‘sustains’ them in these stand-alone units with a high level of responsibility. As the findings will reveal, this trio of words offers multiple lens through which to view the data, yet merge back into a sense of oneness.

In hindsight, ‘Providing labour care in primary units: what makes it work?’ might have been a more hermeneutic phenomenological question to guide this study. I recognise it was the insights from my lived experience of midwifery practice and my master’s thesis (see chapter three) that led me to know that ‘enabling, safeguarding and sustaining’ were all things that mattered. The concern in naming these three aspects is that it might have limited my openness. What I found however, was that of its own accord the study came to be about “what makes it work?” In the dynamic play of practice, enabling safeguarding and sustaining are inextricably intertwined. The stories in each of the three data chapters (presented under the enabling, safeguarding and sustaining framework) could have gone in any of the chapters, for each experience was about ‘everything’. The wholeness was retained because practice is always about ‘what matters’. In some way, I begin this thesis knowing that what makes labour care in primary units work ‘is’ enabling, safeguarding and sustaining. What I did not know was how these vital aspects play out for the midwives who carry the responsibility of providing labour care in the way of working. I wanted to explore the meaning these three words point towards, all in the dynamic play of ‘what makes it work’.

The aims of this research study are:

- To reveal what is enabling, safeguarding, and sustaining midwives to provide labour care in primary units in an all-encompassing holistic way;
- To use findings from this study to inform literature about how midwives provide labour care in primary units and what works;
- To use the findings from this study to inform practice, education, and further research.

The methodological approach of this study is Heideggerian hermeneutic phenomenology, which seeks to reveal that which is covered over and taken for granted in our everyday worlds. Heidegger (1996) stated that phenomenology characterises the ‘how’ of research with particular questions concerned about the ‘things themselves’; something self-evident that we want to understand more. Participants included 11 midwives who work in primary units and three obstetricians who are linked to primary units. All of the units are located within the greater Auckland region of Aotearoa-New Zealand.

In my masters’ research, using a similar approach, I explored the differences for midwives providing labour care at primary units in contrast with large obstetric hospitals. From the data, I revealed a list of skills embodied by midwives working in primary units. When these midwives spoke of their experiences in primary units, their additional skills of working without technology were revealed. When I talk with midwives who prefer providing labour care in primary units, there is something about the way these midwives work; yet neither I nor they could readily explain what factors were enabling, safeguarding, and sustaining them to provide care in this setting. Hence, this study gives me the opportunity to interpret what happens within primary maternity units where the midwives’ practice enables normal birth and enhances good outcomes for birthing women and their babies. The culture of the maternity units and mutual support between employed midwives and self-employed lead maternity carer (LMC) midwives may well contribute to safe care for women and their babies during labour and birth. This study provides guidance on how to protect and preserve the culture of safely facilitating labour and birth in primary units.

### ***Unpacking the Research Question***

The meaning of words is important in a hermeneutic phenomenological research study, therefore sources have been used to ensure the words are congruent with the intent of the question:

Enables – to make something able, to do

Safeguards – protect, preserve, ensure safety of

Sustains – to provide what is needed for something to exist

Which all come together as:

Works – effective operation, manner of working (Merriam Webster, nd).

The words that comprise this research question provide guidance for uncovering how the midwife works in a way that enables her to provide labour care, what safeguards the care and, furthermore, what is sustaining. The notions of enabling, safeguarding and sustaining draw together the parts of the midwife's experience of providing labour care in primary units, into a bigger picture, a more complete understanding and the wholeness of these parts.

### *The 'Midwife'*

Who are the midwives that provide labour care in primary units in Aotearoa-New Zealand? Predominantly, they are self-employed LMC midwives who are responsible for labour care, supported by employed (core) midwives. District Health Boards (DHBs) or trusts that administer the primary unit employ midwives generally on a rostered schedule, to cover shifts over the 24 hour a day, seven days per week. In New Zealand, eligible women are entitled to free, government funded public system maternity care that includes the services from either midwife or general practitioner (GP) LMC providers. Private obstetricians who undertake the LMC role are entitled to charge an additional fee for maternity service. The majority of obstetricians attend women during labour and birth in publicly funded secondary/tertiary hospitals only, not in primary units. There has been a change from GP doctors predominantly being responsible for maternity care (since legislative changes in 1990), to LMC midwives being responsible for coordinating care for 91.3% of New Zealand pregnant women during 2014 (Guilliland & Pairman, 2010; Ministry of Health, 2015). While some GPs might be attracted to maternity care if the model was more flexible, others perceive significant deterrents including the lack of work life balance, funding, team work and peer support (Jaye, Mason, & Miller, 2013; D. Miller, Mason, & Jaye, 2013).

Midwives in New Zealand are educated in a degree programme to be autonomous 'specialists' in normal birth through a minimum of 2400 practice hours, conduct of a minimum 40 births and engagement in over 1900 theory hours; the degree programme is the equivalent of four academic years, delivered in three (Gilkison, Pairman, McAra Couper, Kensington, & James, 2016). The Midwifery Council of New Zealand (2010) defines the scope of midwifery practice and states the midwife works in partnership, on her own responsibility for women during pregnancy, labour, and postpartum up to six weeks, to facilitate births and provide care for the neonate. Furthermore, the midwife

promotes physiological childbirth, identifies complications and accesses medical assistance and implements emergency measures as necessary (Midwifery Council of New Zealand, 2010).

When a midwife obtains a practising certificate in Aotearoa-New Zealand s/he may practise in any setting and has full responsibility for the care of the woman during labour and birth, incorporating the responsibility for referral when necessary. This accountability is onerous and is enmeshed in providing safe care for the woman and baby in line with the Midwifery Council of New Zealand competencies. Newly qualified midwives are supported through the compulsory Midwifery First Year of Practice programme (Dixon et al., 2015), and are able to provide LMC services, including providing labour care in primary units.

Midwives access maternity facilities through a generic nation-wide facility access agreement. The Primary Maternity Service Notice 2007 determines quality parameters, service modules and payment for LMC providers. The Notice (Ministry of Health, 2007) stipulates the aims of the service as follows: women to have a fulfilling outcome through safe care based on partnership, information and choice; pregnancy is recognised as normal for most women; the LMC should provide continuity of care; the LMC facilitates additional care as needed. The LMC is required to be on-call and facilitate care for women over the 24 hour period of time, every day of the week. Calvert (2015) found that LMC midwives must continually work toward 'being ready' in order to provide safe and appropriate care to women.

Midwives in Aotearoa-New Zealand can support birth at home as well as having the option of booking low risk women into a primary unit, unless the region does not have a primary unit within proximity. LMC midwives are autonomous practitioners and carry responsibility for managing intrapartum care in primary units, mostly without doctors on-site (some rural units have access to a general medical doctor). If the woman requires transfer to the secondary/tertiary hospital, clinical responsibility is handed over to the obstetric team. Core midwives help to staff primary units and, on occasions, it is core midwives that manage whatever presents in the unit, including women who have not engaged with maternity care ('unbooked'), women who have changed location and present at the primary unit and/or those requiring emergency care. Core midwives need to be skilled to manage whatever may present, including providing labour care while

substituting for the LMC midwife for a variety of reasons. Core midwives are mindful of what might be developing in the labour room and they develop strategies to be ready to act and assist should the need arise (Calvert, 2015). For the majority of women in Aotearoa-New Zealand, LMC midwives provide continuity of care, accessing additional care when required through referral processes (Ministry of Health, 2012a).

### ***Primary Units in Aotearoa-New Zealand***

The research question for this study is congruent with objectives in the Maternity Notice (Ministry of Health, 2007) that stated primary maternity services need to be safe, informed by evidence, based on partnership, choice and consent. For most women pregnancy is a normal life event. Primary units are in existence for 'normal' low-risk women. Dixon et al. (2012) described primary units as local, family friendly units usually some distance from the obstetric hospital. The Ministry of Health (2013) defined primary units under the Maternity Services DHB funded primary maternity facility tier level two service specifications (previously known as Service Specifications)

The Primary Maternity Facility provides a physical setting for assessment, labour and birth, and postnatal care. It may be a stand-alone facility or unit within a Level 1 or 2 general hospital ... The Primary Maternity Facility, in conjunction with the Lead Maternity Carer (LMC) or DHB-funded Primary Maternity Services Provider, provides primary maternity inpatient services during labour and birth and the postnatal period until discharge or transfer. (Ministry of Health, 2013, p. 2).

The specific objective of the Service is to provide an inpatient maternity service as close to home as possible to allow women to have choice about the setting for non-complex births. Eligible women have access to DHB funded primary maternity facilities during labour and birth and postnatal care until discharge.

Within service components the following applies:

Facility will have sufficient assessment, birth and postnatal rooms for the population serviced by primary maternity services, and for the level of service provided. It will include, but is not limited to, adequate facilities, equipment and consumables for:

- a. LMCs to undertake acute clinical consultations or examinations
- b. monitoring progress of labour and assisting with births
- c. emergency resuscitation and care of mother until transfer of care to secondary or tertiary services if necessary; and
- d. emergency resuscitation and care of the newborn until transfer of care to neonatal services, if necessary, including equipment to maintain baby body warmth. (Ministry of Health, 2013, p. 3).

Under labour and birth specifications, the most relevant component is 5.4.4 stating there will be no epidurals or caesarean sections at a primary facility. There is also no place for medication to induce labour or augment labour. If a neonate requires special care, the baby needs to be transferred to a secondary/tertiary hospital (Ministry of Health, 2013). Primary units vary in geographical location, size, layout and equipment used in labour and birth. In the greater Auckland region, where my study was undertaken, most of the primary units have one or more birthing pools and other aids to assist labouring women, such as birthing balls or a birthing stool.

### **Grounding for this Study**

Birth rates in primary maternity units have fluctuated historically with approximately a quarter of births occurring in these units in the 1960s (Mein Smith, 1986), 28% from 1978-1981 (Rosenblatt, Reinken, & Shoemack, 1985), declining to 12% in 1999, according to the first publication of the Maternity Report for New Zealand (Ministry of Health, 2001). Primary unit births continued to decline, falling to 10.8% in 2010 and further declined to nine percent in 2014 (Ministry of Health, 2012b, 2015).

From the 1970s onward, many small maternity units were closed despite international research that birth in small units was safe and beneficial for women, as evidenced when Tew (who taught medical students statistics) applied corrected statistical analysis to outcomes and birthplace (Kitzinger, 2005; Tew, 1985; Walsh, 2006b; Walsh & Downe, 2004). A consequence of these closures was that many midwives lost skills, knowledge, and confidence in normal childbirth (Donley, 1998; Pairman, 2005; Stojanovic, 2008). Closure of small units was not restricted to the New Zealand landscape of maternity services. In the United Kingdom, Walsh and Downe (2004) reported that 13% of births were in small midwife-led units and birth centres; this decreased to 3% in 2000. A similar ethos existed in Australia where the state was reluctant to risk the existence of small maternity units without on-site back-up from obstetricians (Monk, Tracy, Foureur, & Barclay, 2013).

It is noteworthy that primary units have a place and may better meet the cultural needs of a number of women. Indigenous Māori women are the ethnic group with the highest percentage usage in comparison with all other ethnic groups in Aotearoa-New Zealand (M. Hunter et al., 2011). From the New Zealand Birthplace study (Davis et al., 2011),

additional analysis revealed that 23.06% of Māori women planned to birth in primary units compared to 17.51% of New Zealand European women and 10% of women identifying as Asian. Similarly, the Ministry of Health (2015) reported that 15.3% of Māori women gave birth in a primary unit which was double the proportion of non-Māori women (7.5%) during 2014. Women in the most deprived neighbourhoods were more likely to use primary units than women in the least deprived neighbourhoods (11% vs. 6.9%); this feature might be associated with data that shows women under 20 years of age have greater percentage of birth in primary units as compared with women of increased age.

The Maternity Manifesto (Maternity manifesto-Better beginnings, 2015) lobbies for primary units in order to address social exclusion, reduce the cost of care by known reduction of interventions (including fewer births resulting in caesarean section) and create facilities that are culturally sensitive to whānau and communities in Aotearoa-New Zealand. The manifesto acknowledged the funding vested within DHBs for maternity services and named selected cities that need to provide the option of at least one primary birthing unit in close proximity. Furthermore Overgaard, Fenger-Grøn, and Sandall (2012) validated the importance of freestanding maternity units claiming these units assist to mitigate social disadvantage for women and thus improve positive birth experience.

Concern for declining births in primary units has been noted by the National Maternity Monitoring Group (2016) that prioritised the investigation of availability, use and accessibility of these units alongside the need for DHBs to provide modern facilities with timely access to secondary/tertiary obstetric services. The reason for the decline in women giving birth in recent years is not known; however, it is possible that limited primary units might influence the decline in usage (Kyle & Hendry, 2012) or perhaps perceptions resulting from media (including social media) reporting incidents of poor outcomes within primary units that impacts upon fear for women, families, and potentially midwives (Luce et al., 2016). However, Grigg, Tracy, Daellenbach, Kensington, and Schmied (2014) did not find the media influential in women's decision making regarding place of birth in New Zealand. Instead, women who chose secondary or tertiary hospitals wanted specialist services on hand, while those who selected a primary unit valued the close proximity to home, primary unit atmosphere, and less intervention. In my own LMC practice, I recall sharing information with clients



explaining that obstetric and paediatric doctors were not available at the primary unit, yet experienced midwives were on hand. After this conversation, one client responded that having an obstetrician at every birth would be like having a vet present every time a cow calved. This client held a pragmatic view that women needed to help themselves during labour through employing movement and position changes.

In order for primary units to be utilised, they need to be accessible and acceptable for pregnant women. Closure of rural maternity units was compared by Van Teijlingen and Pitchforth (2010) as similar to the Wal-Mart effect where the large complex threatens the viability of smaller community shops. Organisation of rural maternity care is linked with socio-economic development, local culture, demography, political decision-making and geography. Beere and Brabyn (2006) pointed out that New Zealand geography can create major access issues to maternity services and noted that the model has changed from an equity community focused model to a market model of maternity care with a greater number of Māori women as compared to women of other ethnicities underserved through maternity access being greater than 60 minutes travel distance.

### **Economics of Primary Units**

In a health system that is fiscally constrained and mandated to deliver services that are cost effective and efficient, research which seeks to show safe midwifery care in primary units is timely. In New Zealand, the majority of births occur in the most costly settings, secondary and tertiary obstetric hospitals. The cost of epidural analgesia is estimated as adding an additional 32-36% on to the cost of birth for low-risk women (S. K. Tracy & Tracy, 2003).

Bernitz, Aas, and Øian (2012) undertook a randomised controlled study of 1,111 Norwegian low risk women who were allocated to either midwifery care in a birthing unit or standard ward care where women had access to epidural analgesia and obstetrician input. The authors found a significantly lower use of epidural analgesia and oxytocin augmentation in women who commenced labour in the birthing unit and the authors questioned to what extent these procedures are used due to availability within obstetric led units. The cost for birth in the midwife led birthing unit was less than standard care units ( $p < 0.001$ ) without any compromise in standard of outcome. The authors demonstrated that the cost of postnatal stay increases in tandem with increased use of

interventions. These findings echo those of S. K. Tracy and Tracy (2003). The Birthplace in England Collaborative Group showed that for low-risk women, the total unadjusted mean costs per birth were 1,435 pounds for freestanding midwifery units, 1,461 pounds in alongside midwifery units, and 1,631 pounds in obstetric hospitals (Schroeder et al., 2012).

### **Normal Labour and Birth in Context of Aotearoa-New Zealand**

Viewpoints and definitions of normal birth are abundant and varied. ‘Spontaneous vaginal birth’ in Aotearoa-New Zealand is recorded as birth without obstetric delivery assistance, inclusive of spontaneous breech birth, induction and/or augmentation prior to delivery (Ministry of Health, 2015). In the recent maternity report, the Ministry published benefits associated with spontaneous vaginal birth for the woman, baby and society including the physical and emotional wellbeing of the women and babies. Benefits included: preparing baby for birth, bonding through immediate skin-to-skin contact, ongoing attachment, reducing risk of respiratory difficulties for baby after birth, exposing baby to flora to colonise its intestine, promoting early breastfeeding thereby supporting exclusive breastfeeding for longer duration and an easier transition to motherhood with easier physical recovery following birth (Ministry of Health, 2015).

The Ministry of Health (2015) indicated that 64.8% of women had a spontaneous vaginal birth in 2014, a significant decrease from 67.7% in 2005. There was a statistically significant increase in the proportion of caesarean birth from 23.3% in 2005 to 25.9% in 2014, due to the increase in elective caesarean birth. ‘Normal birth’ is differentiated from spontaneous vaginal birth by excluding induction, augmentation, epidural and episiotomy. Only thirty three percent of women had a ‘normal birth’ in 2014, 23.3% of women giving birth for the first time. A quarter of women had epidural analgesia and are excluded from the ‘normal birth’ category; of these women who had epidural, 42.4% were giving birth for the first time (excluding elective caesareans). The majority of women gave birth at secondary (41.1%) and tertiary (46.6%) units; only 9.1% gave birth in a primary unit and 3.4% had a planned home birth.

In view of the rise in interventions, Davis and Walker (2011) undertook focus groups of 48 LMC midwives in New Zealand to elicit their construct of midwifery. The authors claimed the construct of normal birth was both expanding and contracting with an

example that epidurals were becoming normal. Davis and Walker stated that western binary thinking delineates normal as being within midwifery scope of practice and abnormal as not; instead they propositioned that midwives gauge success by the woman feeling satisfied with her birth experience. Maintaining a sense of normal or normality by minimising medical interventions (Davis & Walker, 2011; Earl & Hunter, 2006) might be very different to categorising the birth as either normal or abnormal. McAra Couper, Jones and Smythe (2010) stated that radical shapers of choice (such as control, predictability, normalising surgery, ease and convenience) need to be exposed as increasing interventions in childbirth and changing women and health professionals' belief in a woman's ability to birth naturally. Perhaps the point of difference is that the space of birth determines what is 'normal' in that space. Primary units do not offer epidural analgesia and are touted as a place for normal birth. A study by Smythe, Payne, Wilson and Wynyard (2009) confirmed that women who live within a community where it is considered 'normal' to birth close to home support preserving and enhancing the possibility of birthing in a primary unit.

### **Methodology for this Study**

Heideggerian and Gadamerian hermeneutic phenomenology was selected to 'hold open' the research questions to participants. This methodology requires a questioning approach that is carried through to the description of texts and beyond. van Manen (2014), who draws upon Heidegger and Gadamer, stated that phenomenology becomes hermeneutical when the method is "essentially interpretive and primarily orientated to the explication of texts" (van Manen, p. 132). The lens of hermeneutic phenomenology enables understandings and insight into the phenomena of the experience of providing labour care in primary units. This method of inquiry seeks to uncover intentions and meanings that are often hidden in text. The interpretations are undertaken with awareness of the researcher's own fore-structure. van Manen stated that we live most experiences without ever bringing them to reflective awareness; whereas the retelling of the experience, such as providing labour care in a primary unit, brings this to reflective cognisance.

### **My Interest in Primary Units**

In keeping with a hermeneutic phenomenological approach, I need to declare my history and the understandings that are likely to influence my pathway through this study. I bring a background that includes my work as a midwife. I began my midwifery career in a

large hospital in 1982; a time when this was assumed to be the safest place, certainly for first time mothers. Yet I knew many women who had their first child in a primary unit. My siblings and I were born in a primary unit. For nine years from 2003-2012, I worked on-call as a LMC case-loading midwife providing care to a small number of women who usually gave birth in a primary unit, while working concurrently in midwifery lecturing and other roles. From a professional standpoint, I have also been an expert witness providing opinion on cases with poor outcomes and, more recently, I was a member of the Midwifery Council of New Zealand for six years that included the period of data collection for this study. It would have placed both myself and the participant in a difficult situation had I heard stories of poor outcomes pointing to possible deficits in midwifery or obstetric care. This does not mean that all outcomes in primary units are positive. Prior to commencing this study, I was acutely aware of media reports accentuating the few cases where a baby had died or suffered morbidity after being born in a primary unit. These experiences both enable and limit my understandings and need to be brought to consciousness with the purpose of challenging and uncovering deeper meaning (Smythe & Spence, 2012).

Following on from my masters' study, I contributed to further research topics. I have been involved in three relevant research endeavours: 1. An evaluative study of a primary unit; 2. Member of the New Zealand Birthplace collaborative research group that published data from outcomes; 3. Sustainability of both LMC and core midwives, Auckland University of Technology project.

Recognition of one's fore-understandings requires a sensitivity to openness. Gadamer (2014) stated that this sensitivity is neither 'neutrality' nor the removal of one's own fore-meanings and prejudices. Openness entails situating one's own meaning within a context of multiple other meanings; multi-layered meanings represent "a fluid multiplicity of possibilities" (Gadamer, p. 281). Where one has experienced something before and thus forms a preconception, this might have a positive or negative value; the essential notion in hermeneutic phenomenology is awareness of one's own bias (Gadamer, 2014).

I bring my inter-mingled experiences to this study and am mindful of my pre-assumptions. Smythe, Ironside, Sims, Swenson and Spence (2008) discussed the nature and the 'who' of the researcher as being fundamental to the thinking within the study.

The experience of the researcher assists with the thinking to enable meaningful and insightful conversations, followed by writing to elucidate the meaning of the experience. Reflecting on my practice, I will share an example of providing labour care in the primary unit:

*This woman was having a subsequent pregnancy after an unfortunate event. She shared information as our partnership developed during antenatal visits. We worked through some health issues and consulted appropriately; she was keen to commence labour in the primary unit and the consultant agreed to “see how you go, transfer if need be”. Labour occurred with promise, but the contractions stalled and progress was not apparent. We discussed further natural strategies and re-visited the birth plan about reasons for consultation/transfer. In the back of my mind, I was weighing up the issues of concern and knew some obstetricians would have wanted her to labour in the obstetric unit. It took me by surprise when she said she wanted to stay in the unit. Thus, we made some changes to the birth room creating more privacy, less light and I promoted calmness with the support team. She was happy to try the shower with her partner massaging pressure points. Knowing the woman and baby’s wellbeing were fine at this point, I along with the supporters retreated giving them their space and sanctuary. Sometime later, she called to say she felt some pressure. While there was a way to go, with gentle reassurance, the baby eventually announced its entrance to tears of relief from everyone.*

Recalling this event challenged my assumptions that multiparous women have easier labours than with their first baby. Perhaps this woman was feeling vulnerable, it appeared that her mistrust of large hospitals only spilled forth in the moment of labour. I was conscious of her health history and aware that physical factors might be causing slow progress. I do not see myself as taking risks, yet, there was much more than her health history in play. She wanted to stay in the primary unit and this was important. I came to a deeper understanding that ‘it depends’ on how the woman and the midwife work their way through the labour. Perhaps caring for a woman in labour is like a ball in play; Gadamer (2014) explained that the ball at times appears to have a life of its own, it cannot be controlled at all times. Perhaps there is an element of less control when providing labour care in primary units; a number of possibilities are in play. Yet, all the time there is the question lurking, should we be transferring ‘now’?

## **Conclusion**

While the media has been known to overstate events when ‘things go wrong’ in primary units, this study will describe what enables safe midwifery care intrapartum and what sustains midwives to provide this care. This does not deny that there is always some risk

associated with birth but that it is essential to establish what works well and what enables midwives to work effectively, in order to sustain midwives providing labour care in primary units. There is equally risk associated with the cascade of interventions that happen in secondary/tertiary hospitals. This study will turn the focus away from the occasional case that goes wrong in primary units (just as happens also in secondary/tertiary obstetric hospitals) and rather seek to explore what it is that works enabling midwives to provide safe care during labour and birth to women in primary maternity settings. Such research is needed to better inform the practice and political arenas.

### **Forthcoming Chapters in Relation to the Research Question**

Chapter Two – In this chapter, the history of birth in colonial New Zealand through to the 1980s is explored. The place of birth changed in location from woman's homes and/or private homes to hospital birth. The reasons for this change in birthplace are described.

Chapter Three – In beginning the literature review, research evidence is examined in relation to the safety of birth in primary units and in relation to care provided by midwives. From this foundation, the second part of the chapter reviews literature pertinent to enabling midwives to provide labour care in primary units and sustaining midwives.

Chapter Four – In this chapter, the philosophical underpinnings of this hermeneutic phenomenological study are discussed with reference to Heidegger and Gadamerian hermeneutics.

Chapter Five – Following on from the methodology, the methods undertaken in this study are reported, linked with philosophical underpinnings and described in order to demonstrate the rigour inherent in the conduct of this study.

Chapter Six – In the first chapter, participant data reveals how they were drawn into primary units. Notions of keeping faith, building and maintaining confidence together with using tact in the moment are described to show what enables midwives to provide labour care in primary units.

Chapter Seven – In the second data chapter, notions of safeguarding are described through working with others, expecting the unexpected, recognising normal and not normal, making the call, leaping ahead and safeguarding through the dread.

Chapter Eight – In the third data chapter, sustaining is shown through dwelling in the primary unit as region, the interface of regions and holding sustaining.

Chapter Nine – In this final chapter, I discuss the interwoven, inextricably linked findings from this study and draw these together in a holistic manner. The metaphor of the hand is used to show what works in relation to providing labour care in primary units. Recommendations for practice, education, and further research are discussed.

## **Chapter Two: History of Primary Units in Aotearoa-New Zealand**

### **Introduction**

Understandings from the past are important to inform understandings of the present, in congruence with temporal philosophy as articulated by Heidegger (1996) and Gadamer (2014). In this chapter I will discuss historical aspects of childbirth in Aotearoa-New Zealand, including the move from women giving birth at home to private and public hospitals. My research question ‘What enables, safeguards and sustains midwives to provide labour care in primary maternity units in Aotearoa-New Zealand?’ is linked with the historical context of small and large maternity hospitals. In particular, I examine how small maternity units developed across the landscape of New Zealand; the functioning of these units is situated within the notion of past, present and future time.

Some health practitioners and lay people wrote their own account of early childbirth in New Zealand while other accounts are captured in historical records. Each writer brings pre-understandings that colour his/her interpretation of what was happening during this period. Small maternity units are enmeshed in the history and progression of maternity services in Aotearoa-New Zealand. Mein Smith (1986) claimed there were tensions between eugenics, the Health Department and community doctors, in tension with doctors and nurse/midwives. Stojanovic (2008) stated that the triangulation of “medicalisation, hospitalisation and nursification” were the most important factors that shaped maternity services and midwifery (p. 165). Donley (1998) provided a critical account of the decline in homebirths, midwives loss of autonomy and doctors acquisition of power. It is apparent that historians differ in their analytical lens; however, most acknowledge it was the significance of mortality during childbirth that steered change from birth at home to hospital, from nurse/midwife attendance to doctor attendance and accompaniment of technology.

I will begin with an overview of childbirth conditions prior to the 19<sup>th</sup> century in Aotearoa-New Zealand. Following the turn of the century, midwives became regulated. Puerperal sepsis caused increasing concern to health officials and somewhat later to the innocent public. Strategies to eliminate puerperal sepsis impacted upon private maternity homes, small maternity units and childbirth attendants. Painless childbirth, safer childbirth and free maternity services drove the increase in hospital confinement. From



the 1960s, regionalisation of services conspired against the continuation of many small maternity units. I conclude this chapter by discussing the impact of closure of primary maternity units and link the themes from the history of childbirth in Aotearoa-New Zealand with my research question.

### **Māori Childbirth**

For Māori, childbirth is a tapu – meaning sacred – process. It is important to acknowledge Te Tiriti o Waitangi (The Treaty of Waitangi) signed in 1840 by a number of Māori chiefs and representatives of British colonists. It is beyond the scope of this study to detail Te Tiriti o Waitangi; however, the indigenous Māori people endured loss of governance, land and resources alongside loss of traditional childbirth through colonisation of Aotearoa-New Zealand. Te Tiriti affords protection and benefits for people with New Zealand citizenship, which likely implies good health (Durie, 2008; Leatham, 2014). Māori managed childbirth according to culture that might differ between areas or regions. Integral to childbirth is ‘whenua’ with dual meaning of land and placenta that nourishes the baby; it is important for Māori wellbeing that the placenta is returned to earth in traditional custom (Le Grice & Braun, 2016; Wepa & Huia, 2006). Le Grice and Braun (2016) described traditional attendants (men and women) who assisted women by mirroring their position of squatting and bracing their contractions; the whare Kōhanga or special birthing hut was sometimes used by Māori. Wepa and Huia (2006) offered the following glimpse of traditional childbirth for Māori:

During childbirth the tapuhi or midwives used a range of techniques to assist the woman. They included karakia (prayer), waiata (songs), laughter, storytelling, rongoa, mirimiri and warm baths. The woman would not lie down during labour, preferring to be in a squatting position. As well as the knees of the tapuhi, two vertical posts were constructed to assist her to brace against. Upon delivery the baby would have remaining excretions removed by the tapuhi by taking a deep inward breath over his/her mouth. As the baby took its first breath a pronouncement to the world could be heard ‘Tihei mauri ora!’ (It is the breath of life!). It is at this moment that the baby is considered to receive a spirit connecting him or her eternally with a tipuna (ancestor). The pito (umbilical area of the baby) would be treated, the baby washed and wrapped. Mirimiri would be performed on the woman until the whenua was delivered soon after. It would then be checked to ensure it was intact. A kete (flax-woven bag) or epu (clay pot) would house the whenua (placenta)...until it could be buried at a later date.(p. 8).

For Māori, traditional childbirth entailed rituals and spirituality. These features are being reignited by some; karakia and waiata are not uncommon for Māori during or after the birth. Early records suggest Māori women had great fortitude and some gave birth

unattended outdoors. However, should complications arise, the *tohunga*, who was an expert of rituals and healer, might be called upon (Clarke, 2012). In the late 1800s Christina Simonsen was known to assist Māori women in childbirth near Nelson where they gave birth in surrounds of fern or native manuka and continued with their work post birth. In contrast, European women mostly partook in ‘lying-in’ for at least a week after the birth. Colonisation exposed Māori to many diseases that devastated the population and the Tohunga Suppression Act in 1907 further restricted Māori traditional practice (Durie, 2000).

The Department of Health provided district nurses to work with Māori in the early 20<sup>th</sup> century and doctors were called in emergencies during childbirth. Both practitioners promoted birth in hospital settings. The 1937 government Committee of Inquiry reported maternal and infant mortality was higher for Māori and urged hospital confinement. While Māori women continued to birth outside of hospital longer than European women, legislative and social change meant that Māori yielded to birth in hospital settings (Papps & Olssen, 1997). Before describing the move to hospitals, I will discuss the context of Aotearoa-New Zealand in the 1800-1900s to situate the reality for women experiencing childbirth.

### **Early History of Maternity in Aotearoa-New Zealand**

Clarke (2012) stated that women were 50 times more likely to die during childbirth in the late 19<sup>th</sup> century when compared with 2012. Furthermore, maternal deaths were underestimated because reporting outcomes for indigenous Māori women was not compulsory until 1913. Deaths in general were either under-reported or maternal death was frequently attributed to another cause. While tuberculosis caused more deaths than childbirth, colonist Maria Atkinson expressed her fear of childbirth. She wrote to her sister-in-law in 1864 requesting that her young daughter return from a visit to cousins, in case things went wrong for Maria during her confinement:

I fancy if anything should go wrong with me, as it has done with others who seemed as strong and healthy as I am now, it would seem sadder not to have her to say goodbye to....You must not think I have any gloomy forebodings for I am quite cheerful and see no reason to believe I shall do otherwise than well, but one can never forget how many poor women have been full of hope and reasonable expectations of happiness whilst the Angel of death was waiting for them close at hand. (Clarke, pp. 174-175).

Maria describes herself as strong and robust yet knows of ‘the angel of death’ who waits nearby during birth and postpartum. Knowledge of neighbours or family who had been taken meant that the peril of approaching birth is likely to have clouded many women’s minds. Relatively few births occurred in New Zealand hospitals during the mid to late 1800s. Hospitals were only for the poor who needed welfare. Perhaps there was also an overriding fear of childbed fever. Knowledge of childbed fever (puerperal sepsis) in Europe was a significant deterrent against hospital confinement in New Zealand. Puerperal sepsis spread rapidly between patients and became associated with wound infection and septicaemia (Clarke, 2012). Maternal mortality was known to be higher in hospitals such as the Glasgow lying-in hospital where 1 in 77 women died during 1852 compared with 1 in 325 women who gave birth in their own dwellings (Shelton, 2012).

In the 1840s, Holmes and Semmelweis warned of puerperal fever spread from attendants, particularly the hands of doctors and medical students who performed autopsies prior to attending maternity patients. However, their theory of handwashing, cleaning and disinfectant was known yet not globally accepted. Some doctors considered the disease ‘natural’ and a “fatal complication of childbirth” (Clarke, 2012, p. 184). In 1885, a woman admitted to Wellington (New Zealand) with puerperal fever subsequently died and four patients in nearby wards became ill with the spread of infection. Clarke stated there was wide publicity regarding this outbreak with an inquiry that investigated the medical practitioner who admitted the fated woman. This case served to increase reluctance among doctors to admit a woman suffering from puerperal sepsis to a hospital ward.

Puerperal sepsis was not limited to hospitals. Clarke (2012) reflected on a case in 1885 where the monthly nurse left an infected woman to attend another labouring woman contrary to the doctor’s instruction. Nurses lacked knowledge of infection and needed to work for their living, in similar manner to the poor whom they were attending. Dobbie (1990) described New Zealand seaports at the turn of the century as dirty make-shift shacks without a clean water supply where the poor bore their children and puerperal fever was rife.

Clarke (2012) examined preserved hospital records that revealed a very small number of women were admitted as ‘lying-in’ maternity patients in public hospitals during the 19<sup>th</sup> century. Dunedin had opened a separate lying-in ward in response to the rise in

pregnancies to those without financial or social support during the gold rush; some 164 women were admitted during 1861-1878. The separation of maternity cases from general hospital patients was intentional because of puerperal fever but, unfortunately, the separation of patients was not full proof. From scrutiny of an admission and discharge register, Clarke (2012) discovered three sequential deaths from puerperal fever in this lying-in ward during 1878. While Dunedin hospital suppressed this outbreak, such cases reinforced a belief that home birth was safer for married women who had an abode. Dunedin's lying-in beds were closed in 1887 because of increasing fear of puerperal fever and concern by the inspector of hospitals that the lying-in ward was located in a general hospital (Board of Health, 1976). Nevertheless, in the period after closure of the lying-in ward, Clarke (2012) revealed that many single women without accommodation were confined in homes of local nurses. Some of these women were attended in labour by Dunedin medical students with, or without, obstetrician oversight.

The care of public maternity 'cases' in private homes (owned by doctors and nurses) was less than ideal in the late 1800s. In order to meet the needs of destitute homeless pregnant women, the Otago Benevolent Institution (the equivalent to a poorhouse) was established in 1888. Women were attended by the nurse manager or doctors and medical students (Clarke, 2012). In 1890, Mary Leslie, a single woman having her second baby was admitted to this institution; her first child was born in Dunedin lying-in ward after a difficult labour with nine hours under chloroform that ended in craniotomy (crushing of baby's skull) to achieve delivery. This procedure was used when ergot medication, turning (of the baby) and forceps failed. In her second labour, Leslie was attended by doctors from Dunedin hospital who discussed the failure of baby to descend in the pelvis. Options included craniotomy or performing a caesarean with use of chloroform anaesthesia. When the latter option was undertaken, this became the first documented case in New Zealand wherein mother and baby survived a caesarean (Clarke, 2012).

### ***Assisting Women in Childbirth***

In the early 19<sup>th</sup> century some, but not all, Wesleyan missionary wives undertook weeks of midwifery training in an English lying-in ward prior to immigrating to New Zealand with intent to assist their own in childbirth. There was reluctance to seek help from Māori despite living in the same community (Clarke, 2012). The lack of requirement to record the birth attendant in early years hampered attempts to ascertain who attended the majority of European women during childbirth. However, V. Fleming (1998) stated there

was little evidence of midwives in the early years of colonisation, although Nightingale trained nurses were encouraged to immigrate in the late 19<sup>th</sup> century, some with nursing and midwifery training. Inquest findings of maternal deaths from salvaged newspapers in the 1800's confirm that civilians attended women in labour. A midwife and/or doctor might be sought when complications arose or deterioration of the woman's condition was observable. In one case (New Zealand Herald, 1865), the husband declined to summon the doctor in time despite requests from the civilian attending the woman followed by the midwife. The jury found that the 34-year-old woman having her 11<sup>th</sup> baby died as a result by the visitation of God and rupture of the womb after hard labour. The jury lamented that the deceased had no proper medical attention. The inference from the inquest finding is that doctor presence during childbirth was prudent, particularly when complications ensued. However, in this young country, there were too few doctors and midwives.

The earliest list of registered midwives in New Zealand was in 1906 and provides evidence that the majority had no formal training; 662 untrained women outnumbered 63 trained midwives. This confirms that most women must have been attended in childbirth by untrained midwives and/or doctors. Several trained and untrained midwives offered confinement in private homes from the late 19<sup>th</sup> century as shown by advertisements in newspapers; selected advertisements offered the addition of medical assistance if needed. Some doctors attended many women in childbirth with one Nelson doctor attending 2,589 labouring women from 1859-1885; while another doctor in New Plymouth attended 2,844 women in labour between 1877 and 1894, averaging three women per week (Clarke, 2012).

Doctors employed lay or traditional midwives sometimes known as 'Gamps' (untrained women), handywomen or monthly nurses to attend women in their own home (Clarke, 2012). The monthly nurse was the woman who also took over care of the household for a month after the birth (Donley, 1998; Stojanovic, 2008). The term Gamp derived from Dickens fictitious character of a drunken midwife named Mrs Sairey Gamp (Mein Smith, 1986). They were expected to call for the doctor near the end of first stage of labour and to assist the doctor with the delivery. Gordon (1955) who was a GP, narrated tragic events with four women dying in her first 200 cases at Taranaki. She described one woman who ruptured her uterus when a Gamp only notified her of the labour once she saw an arm

hanging out; this case fired Gordon's determination to obtain a Fellowship of Surgeons to enable her to perform hysterectomy when necessary.

Transition from midwife to doctor care, for the majority of women in New Zealand, became more usual between 1920 and 1924, assisted by insurance schemes that covered the doctor's fee. Confinement with doctor attendance and hospital birth became the custom (Mein Smith, 1986). In the early 20<sup>th</sup> century, doctors favoured private maternity homes and recommended these to their middle-class patients. Thus, maternity hospitals evolved from a place for homeless destitute women to the place accepted by the majority of all classes of women by 1930. This change occurred in a relatively short period of time because hospitals offered relief from the extreme hardship of domestic chores, particularly for women in rural areas who worked on the farm in addition to managing household duties. The promise of painless childbirth was a rather considerable lure for women to access hospitals for birth in the early 20<sup>th</sup> century (Dobbie, 1990; Donley, 1998).

### **Regulation and St Helens Hospitals**

Following the British model of regulation, the New Zealand government passed the Midwives Act in 1904 enabling women who had practised for more than three years and were of good character, to pay the fee required and register as Class B midwives. Class A midwives were those who had a certificate in formal training. Women who lacked three years 'midwifery' experience at the time of the Act were allowed to work under close supervision of a doctor due to the shortage of midwives. Mein Smith (1986) reported that most Class B category midwives and unregistered women (later called maternity nurses) relied on doctors for their livelihood. Midwives who were trained overseas or in New Zealand St Helens hospitals (Class A midwives) were able to practise without doctors. These midwives allegedly had sufficient confidence in themselves to report incidents of concern to the Department of Health.

Doctors who owned, or part owned, cottage maternity hospitals were concerned with the introduction of state controlled midwifery in 1904. Alongside was the development of St Helens hospitals for the wives of working class men (where a minimal fee was paid) and for training midwives (Bryder, 2014; Donley, 1998). Doctors viewed trained midwives and the St Helens hospitals as competing with their fee paying maternity patients.

It was Grace Neill, Assistant Director of Hospitals, who instigated midwifery training out of concern for the unsanitary dangerous conditions in which working men's wives gave birth and the ignorance of some who attended them (Dobbie, 1990). The first of the St Helens hospitals opened in Wellington 1905 followed by Dunedin and Auckland in 1906. By 1920, St Helens hospitals existed in Christchurch, Gisborne, Wanganui and Invercargill (Stojanovic, 2008). The training of midwives led to proliferation of private maternity homes opening throughout New Zealand with former St Helens midwives proudly advertising their experience (Truttman, 2014). The Private Hospitals Act 1906 detailed requirements of a lying-in hospital including the requirement of a resident midwife. Private hospital licenses had to be renewed annually and all premises were subject to inspection by the Department of Health. Truttman (2014) claimed that government funded (public) provincial hospitals were established alongside maternity annexes such as the Costley building at Greenlane, Auckland. The building of public and private maternity homes stalled in 1914 with the outbreak of war and many New Zealand nurses volunteering their service overseas.

Births at home, or someone else's home, prevailed in 1920 with 65% of births at home or in small unlicensed one-bed homes run by a maternity nurse where either a medical practitioner or registered midwife was the designated manager. Private hospitals (defined as having two or more beds) accounted for 26% of births; 5 % were in hospital board and charitable hospitals with only 4 % in St Helens hospitals (Mein Smith, 1986). Saint Helens hospitals augmented public acceptance of hospital birth and, where St Helens were unavailable, hospital boards opened small maternity units, wards, or annexes. The Nurses and Midwives Act 1925 ensured uniformity of training; the existing programme became maternity nurse training and a new midwifery postgraduate course was established (Mein Smith, 1986).

While maternity hospitals and midwives were regulated, the Health Department were reluctant to impose rules upon doctors, although the doctors frequently learnt skills from the highly trained midwives. Mein Smith (1986) stated that older doctors did not necessarily accept asepsis holding belief that childbirth fever was caused by the woman, while younger doctors recognised that nurses and midwives were better trained than themselves in midwifery.

## **Use of Twilight Sleep**

Twilight sleep or painless childbirth was trialled by Dr. Doris Gordon in 1918 when anticipating a long labour with a woman having her fourth child at home in Taranaki New Zealand. Gordon (1955) described how she administered morphia and scopolamine telling the Gamp to be quiet and let the patient sleep and she would return in one hour to administer further injections. To her chagrin, Gordon returned to the patient sipping tea and Gamp bathing baby. Gordon therefore decided not to use twilight sleep again in a private house or without a trained nurse. Doctors preferred to administer twilight sleep causing sedation and amnesia in hospitals with skilled attendants, thereby increasing hospital confinement for women wanting painless childbirth. Gordon admitted her driving obsession to learn more about pain relief but she needed general experience in midwifery and clientele on which to work. She claimed to have mastered the art by having babies herself with use of twilight sleep and the “creative medley of delivering or being delivered” (Gordon, p. 150). Gordon recommended that twilight sleep be used for all those who sought partial or total oblivion but withheld from mothers with twins, toxæmia or premature babies.

Gordon (1955) argued in 1924 that twilight sleep would support the government to “make easy for women their contribution to the nation’s wealth...in the womb of British womanhood lies the Empire’s progress and her strength” (pp. 158-159). To achieve this, she advocated the establishment of more and better equipped hospitals with doctors available to give advice on pain relief and manage complications. Gordon argued that obstetrical accidents would decrease by specially trained doctors only giving pain relief. She further argued the cost-benefit; it would be political wisdom to make childbirth easy for women contributing to the nation’s wealth in line with eugenic views of reproduction.

Twilight sleep was not without side-effects. The Health Department was concerned about respiratory depression of babies and favoured use of chloroform because it could be administered by midwives and was cheaper. Indeed, twilight sleep was associated with privilege and middle-class women who could afford the fee for doctor, fee for twilight sleep, and fee for private hospital. The lure of twilight sleep led to more births in hospitals and increasing interventions because women were sedated, unable to assist the birth process. Internal examinations were increased along with the propensity for forceps



deliveries that were assumed to be associated with an increased rate of puerperal sepsis (Donley, 1998; Pairman, 2005).

### **Puerperal Sepsis**

Maternal mortality from puerperal sepsis could affect women after normal and/or complicated birth and be transmitted in hospital or community, from nurse, midwife, or doctor. The Children's Bureau of the United States Department of Labour revealed that New Zealand had the second highest mortality rate in the developed world, after the United States. The fact that this became public knowledge in 1921, hampered the Government and doctor's encouragement toward achieving higher birth rates (Mein Smith, 1986). Dr. Truby King was therefore charged with reducing maternal mortality. King used Plunket educational material against "meddlesome midwifery"; accusing doctors of forceps delivery that harmed women and caused brain injury to babies (Mein Smith, 1986, p. 9). However, King's expertise was in mental health; he did not have obstetrical experience and his criticisms of meddlesome midwifery angered GPs. Dr. Valintine, Director General of Health, initiated a Board of Health Special Committee in 1921 to investigate a more pragmatic approach to reducing maternal mortality in New Zealand. In 1921, Valintine was quoted by the press as criticising 'hurried midwifery' alongside the failure of doctors to report cases of puerperal sepsis. The 1921 committee concluded that deaths from puerperal sepsis were mostly preventable, yet refused to implicate doctors 'meddling'. Instead, the committee suggested puerperal sepsis was caused by virulence of organisms, diminished resistance of individuals, unsuitable surroundings and patient/family demand for instrumental deliveries (Donley, 1998; Mein Smith, 1986).

From the findings of the 1921 committee, Valintine was prompted to increase the frequency of hospital inspections and commence investigations into individual cases of death. The campaign against maternal mortality was driven by two other doctors in New Zealand. Jellett, the former master of the Rotunda hospital in Dublin, volunteered to inspect maternity hospitals throughout New Zealand and favoured the closure of small hospitals. The other doctor was Paget, a GP with extensive experience in rural New Zealand. Paget favoured home birth for normal maternity cases because it was cheaper; and in order to make childbirth safer for those needing assistance, he suggested building small public maternity hospitals. Undoubtedly Paget's rural experience in New Zealand

(including Taranaki where he sold his private hospital to the Gordons) had given him a different perspective. When the 1921 maternal mortality report was published, GPs, including Doris Gordon, resented state interference regarding inspection of private hospitals. Donley (1998) revealed that Gordon's own private hospital had an alarming high forceps rate causing the Department of Health to threaten closure of her hospital on several occasions. Gordon contended that the Department threatened to shut down her hospital in 1923 if she continued to experiment with twilight sleep drugs. Gordon counterclaimed that St Helens state hospital in Wellington had cases of sepsis, yet the Department would not admit to this.

Further public outcry occurred in 1923 when six cases of puerperal sepsis, five of whom died, occurred in the Kelvin private maternity hospital in Remuera, Auckland (Mein Smith, 1986; Truttman, 2014). The Kelvin hospital accommodated 'middle-class' women attended by doctors. Yet, according to Mein Smith (1986), the ensuing inquiry defended doctors, ignored the implications of forceps use and stated that the Department of Health was responsible. The Department of Health retorted that notifications of puerperal sepsis were either absent or late hampering their jurisdiction. Thereafter, the Department relied on hospital matrons for notification of infection through the immediate reporting of elevated temperatures. Daily recording of maternal temperatures remained in practice for years after this outbreak of puerperal sepsis and was common practice during my maternity experience in 1976 within the Auckland hospital board.

In 1924 Paget was appointed an Inspector of private hospitals and undertook a tour of all 250 hospitals in New Zealand. He was appalled by the lack of sterilising equipment and contamination of instruments. The Safe Maternity Campaign launched in 1924 focussed on antenatal care, asepsis, hospital policy and standards, alongside midwifery training. Paget's responsibility included control of the nursing profession and he insisted upon standard aseptic technique during labour (Mein Smith, 1986). Adherence to asepsis by midwives was successful and, in time, this was adopted somewhat reluctantly by the medical profession. However, strict adherence to aseptic technique put a number of the Class B older midwives out of business because the cost of supplies and equipment was prohibitive.

Forceps rates were recorded by the Department of Health in 1926 and showed 56% forceps rates in two private hospitals, whereas the forceps rates across St Helens hospitals

averaged only 3.8% (Donley, 1998). In 1927-8, another rise in mortality occurred with half of the deaths (70 women) attributed to puerperal sepsis. The usual pattern was that around a third of maternal deaths was due to sepsis. Once again, conflict arose with the Department of Health (who posed exogenous cause) as compared to Gordon, from the newly formed Obstetrical Society who attributed cause to microbes virulence suggested by Bonney in London (Gordon, 1955). The Obstetrical Society continued to promote the autogenous theory that women harboured the disease. Paget reassured the public that no epidemic had occurred in licensed hospitals thus justifying the Health Department regulations after the Auckland Kelvin hospital debacle.

The Department of Health maintained its stance that sepsis was likely carried by doctors who dealt with a greater variety of problems as opposed to midwives who only did maternity. Jellett championed the view that vaginal examinations, forceps and obstetric surgery were contributory factors. The medical profession had unwittingly been responsible for spread of sepsis more so than midwives because they regularly carried out digital (vaginal or rectal) examinations. The design of hospitals meant general and maternity patients were co-located. The use of medical instruments, including forceps, facilitated the transmission of bacteria. Where sepsis was suspected through notification of an elevated temperature, the Department of Health transferred the woman to a general hospital. In cases where sepsis developed, the Department would close the maternity hospital that had admitted the woman to ensure no other cases/women became infected. The Department had authority to suspend doctors or midwives from practice if they deemed a practitioner responsible for causing puerperal sepsis. Trained nurses were known to report cases of malpractice to the Health Department and this exacerbated tension between doctors and nurses.

One example that highlighted ongoing tension occurred when a nurse inspector enforced the four-day closure of a private hospital in Invercargill, although in this case the woman isolated did not establish puerperal sepsis. In 1929 a meeting occurred between the Health Department and the Obstetrical Society whereby the latter refused to accept that nurses could authorise closure of private hospitals. Closure caused loss of income for GPs and tainted the reputation of private hospitals (Mein Smith, 1986). The Department of Health agreed that only Medical Officers of Health would have authority to close a hospital. However, the Department would continue to be held responsible for either unnecessary closure or, alternatively, not closing a hospital promptly that could result in

further cases of puerperal sepsis. In 1930, Jellett put an additional strain on the relationship with the Obstetrical Society by asking the Medical Officers of Health to bracket cases of puerperal sepsis to the same doctor or midwife; one doctor in Canterbury was shown to have three cases of puerperal sepsis occurring within one week. The Department's insistence on improved training for midwives had ensured asepsis during birth. Asepsis was not as ingrained in doctor's technique, possibly because the dissemination of puerperal sepsis had not been 'proven' and many doctors dismissed the Health Department's policies.

Nevertheless, improvements in asepsis had resulted from interventions by the Department of Health. These included standards for aseptic technique (H-Mt.20); enforced sterilisation of equipment in private and public hospitals and lawful inspections of facilities. The aseptic techniques practised by midwives subtly influenced aseptic practice by GPs. Paget's introduction of affordable sterilisers into private hospitals, substituted by a simple two bowl steriliser for smaller maternity hospitals or homebirth, was a turning point in the reduction of puerperal sepsis. Implementation of cost-effective sterilisers is likely to have saved private maternity hospitals from further outbreaks of puerperal sepsis and thus preserved the income of many doctors who owned private hospitals (Mein Smith, 1986). These private hospitals were often converted older houses, yet filled a role in New Zealand's maternity system. Still, the medical profession were keen to access better equipped public hospitals. To this end, they lobbied the Department of Health for private fee-paying patients to be attended by their own GP within the more up to date public hospital premises.

Mein Smith (1986) reported the New Zealand death rate from puerperal sepsis declined significantly after 1927 to a low point of 0.33 per 1000 live births in 1935. This was achieved without aid of antibiotics; sulphonamides became available only in late 1930s and penicillin in 1940s. By 1932, New Zealand had the lowest death rate from puerperal sepsis compared to eight countries using the same criteria and surpassed the Netherlands. It was 1935 when Leonard and Dora Colebrook identified the bacteria causing puerperal sepsis and thus justified the long held belief by the New Zealand Department of Health that puerperal sepsis was external in origin.

## **The Rise of Obstetrics**

The Obstetrical Society had been formed in 1927 to counter the monopolisation of maternity (known as 'midwifery') by the Department of Health (Jones, 2016). The Society recognised the need to educate doctors in relation to antenatal care and to increase the number of births required for doctors to gain experience. New Zealand doctors trained in 'midwifery' were required to conduct five births while their United Kingdom counterparts conducted 20 births. While Jellett from the Department favoured large hospitals, he also believed that the majority of women should be attended by midwives, similar to the Dutch model of care viewing childbirth as a normal process for most women with no more than 10-20% requiring the assistance of doctors (Mein Smith, 1986). In contrast to Jellett's view, Dr. Doris Gordon, as instigator of the Obstetrical Society, urged doctors to publicise the highly dangerous nature of childbirth using puerperal sepsis and toxæmia as evidence. Gordon's ability to persuade doctors and the public of the peril of natural childbirth contributed to the irreversible thrust toward hospital birth, managed birth and doctor directed care in New Zealand.

While puerperal sepsis had subsided by 1935, the Health Department's approach to managing toxæmia had not succeeded, hence the Department relied on the Obstetrical Society for guidance (Mein Smith, 1986). A further Committee of Inquiry into maternity services in 1937-8 heard the debate on private versus public maternity and the proposed size of maternity hospitals. Jellett continued to lobby for large public hospitals that catered for resident and training doctors; medical students experience had expanded since gaining access to the St Helens hospitals from 1929 (Pairman, 2005). Donley (1998) described the infiltration of medical students and house surgeons into St Helens hospitals as a means of doctors obtaining 'clinical material' that led to a doctor-hospital orientated maternity service. On the other hand, Paget's background in rural maternity influenced his encouragement of building small maternity hospitals in rural areas to serve the small and scattered population of New Zealand.

The Labour government were sympathetic to women's groups who lobbied for the pain relief that was available in private hospitals to be available to women using public hospitals. Gordon (1955) had provided the Prime Minister's wife with a copy of her thesis on twilight sleep and medical pressure persuaded the government to allow for continuity

of service by a doctor. Of significance, the majority of women's organisations favoured childbirth in hospital and demanded a free service from the State.

### **Changes with the Labour Government Reform**

The Labour government passed social security legislation in 1939 providing for doctor attendance during pregnancy, labour and after childbirth. This ended any suggestion that doctor attendance was the domain of wealthy women only. Hospital Boards were charged with the provision of sufficient maternity beds to meet the demand for increasing hospital births (Stojanovic, 2008). V. Fleming (1998) stated that a further reduction in homebirths occurred as a direct result of free hospital confinement. This resulted in an increased demand for small hospitals throughout New Zealand.

Free maternity inpatient care inclusive of 14 day postnatal stay stretched maternity services and put pressure upon Hospital Boards to urgently provide additional maternity beds. In this period, Gordon (1955) asserted that private hospitals closed at the rate of one per month as a result of increasing cost attributed to the five day working week introduced by the Labour Government. New Zealand experienced a post war baby boom from 1945 alongside a shortage of nurses. Private maternity hospitals were understaffed and struggled with managing the 40 hour week and higher wages for domestic staff (Dobbie, 1990). The shortage of maternity beds was further highlighted by a request to Doris Gordon (who was by then employed by the Department of Health) to procure any unused soldier wards for maternity beds. Similarly, taxi drivers reported leaving women at the door of a large maternity unit despite a desperate matron saying there were no beds available (Gordon, 1955).

### **Decline of Small Maternity Units in Aotearoa-New Zealand**

Yet another Maternity Services Committee was established in 1960 to advise the Minister of Health on matters concerning the pregnant woman and her child (Board of Health, 1976). The committee's work extended over a lengthy period. Beginning in 1968, the Auckland professor of obstetrics and a senior health department official commenced an assessment of 160 maternity units in New Zealand. Over a four year period, they visited every maternity unit in the country except a small unit on the Chatham Islands (Board of Health, 1976). The Maternity Services Report was accepted by the government and further obstetric regulations were implemented in 1975. Major changes were made with

regard to equipment, staffing and procedures. In the same decade, in 1971, the Nurses Act came into force by removing midwives from the title and added the requirement that a medical practitioner take responsibility for the care of the patient (Pairman, 2005; Papps & Olssen, 1997). While the changes made it an offence to care for a patient without the supervision of a medical practitioner, this loss of autonomy had greatest impact upon domiciliary midwives. For midwives practising in hospitals, medical practitioners were named as responsible for care, although not necessarily in attendance. Regionalisation or centralisation of maternity services from 1960 to 1980 featured specialisation in obstetric and perinatal service, new technology and resulted in the rising cost of maternity care (Rosenblatt, Reinken, & Shoemack, 1984). Of particular relevance to my research question was the closure of small maternity units.

As early as the 1920s, Jellett favoured large teaching hospitals modelled on the Rotunda in Dublin and suggested closure of some 200 private maternity homes in New Zealand. Records of private maternity homes are incomplete; however, most homes closed with stringent requirements for sterilisation equipment and after the Kelvin maternity home tragedy associated with puerperal sepsis. Some 94 private maternity beds were available in the Auckland area in 1938, yet further decline of beds arose from competition by nearby hospital board maternity hospitals that provided services without fees. It was also impacted by nurses and midwives ageing and/or becoming ill and leaving their private practice to retire in the 1940s-1960s (Truttman, 2014). The second wave of small maternity unit closures, that is all public hospital board facilities, occurred from 1970-1984 when 33 closed; 29 of these were in rural areas. This figure represents closure of almost a third of small maternity units functioning in New Zealand.

Rosenblatt, a Harvard medical graduate, was invited to undertake research into New Zealand's maternity service. He commented that the type of 'single-specialty' maternity hospital was not seen in most other westernised countries with small maternity hospitals providing free GP and midwife care (Rosenblatt et al., 1984). Small maternity units serviced a quarter of the births in New Zealand at this time. Access to maternity units changed from almost every geographical county in New Zealand having at least one public maternity unit to a systematic process of planned closure, initially due to concerns of quality, particularly very small units. Latter closures were initiated by Hospital Boards needing to curb spending and the view that small units were costly and inefficient.

Common reasons for closure included a falling birth rate in the previous five years, particularly when alternative facilities were considered to be within a reasonable distance (Rosenblatt et al., 1984). Private hospitals also closed but did not undergo formal government review; hence these are not covered in the Rosenblatt report. Yet, the government influence was apparent when Prime Minister Muldoon announced that private maternity hospitals were a thing of the past in April 1979. All private maternity hospitals in Auckland closed to enable maximum usage of beds at National Women's hospital (National Womens Health, nd). The Mater Maternity Unit in Auckland was the largest private hospital to close resulting in an additional 600 women a year to have their babies at National Women's

Rural units were viewed by the Maternity Services committee as "inefficient, overbedded, underutilized, difficult to manage and of questionable quality" (Rosenblatt et al., 1984, p. 34). In 1982 the Auckland area consisted of the following small units: Pukekohe, Papakura, Howick, Warkworth and Helensville. Waitakere and North Shore were classified as Level 1 facilities at this time (without caesarean and neonatal special care facilities), yet both units had well in excess of 20 maternity beds, 36 and 44 respectively and this was atypical of the smaller units listed above. One of many small units to close during this period was Franklin Memorial Hospital in Waiuku, the unit where I was born that closed in 1977. While Pukekohe hosts a small maternity unit, this is 20 kilometres from the old Franklin unit that served a small town and the remote rural area of the Awhitu peninsular.

Despite Rosenblatt et al. (1984) having met requirements of a detailed report, the Department of Health embargoed publication because recommendations did not fit with regionalisation of maternity services. Copies of the report became available only after appeal to the Ombudsman under the Freedom of Information Act (Donley, 1998). The authors stated that closure of small maternity units was not justified by the assumption of increased perinatal mortality.

Rosenblatt et al. (1984) concluded there is no evidence to suggest that small hospitals in New Zealand were unsafe and stated that the system of care was more tightly organised and uniform in comparison with the United States. Published in the *Lancet*, Rosenblatt et al. (1985) stated categorically that the lowest perinatal mortality rates occurred in the smallest hospitals where GPs and midwives were responsible for most normal deliveries.



There was no evidence to suggest that units with less than 100 births per annum were less safe than units with a higher volume of births. Furthermore, the authors summarised that:

the significantly lower perinatal mortality rates of normal-weight infants in level 1 hospitals by comparison with level 2 and 3 facilities may indicate that low-risk mothers fare better in low technology environments. (Rosenblatt et al., p. 431).

In their analysis, Rosenblatt et al. (1984) had undertaken detailed matching of closed rural hospitals with a comparison hospital in the same Hospital Board for exactly the same time period preceding closure. The same Hospital Board was used to control for historical and secular trends over the 20-year period preceding closure of rural units. Logistic regression and sensitivity analysis was used to determine characteristics associated with closures from 1970-1983. Findings showed that closed hospitals had precipitate decrease in births, yet the comparison hospitals similarly experienced declining birth numbers. Size was a distinguishing factor where closed hospitals had statistically significant fewer numbers of beds, admissions and lesser births annually. The authors noted there did not appear to be a sentinel event that preceded closure and that utilisation of small hospitals is linked to demographics whereby provinces with sparsely populated areas had fewer births. In 1970, some 98 public maternity hospitals reported births; by 1984, 26 of these hospitals had closed. Hospitals with fewer births located near a base hospital were most at risk for closure. The authors predicted that a further 26 rural maternity hospitals operating in 1984 would close in the future.

Rosenblatt et al. (1984) added that any successful regionalised perinatal system must include a safe and expeditious mechanism for transport. They noted that those working in smaller hospitals frequently felt like second class citizens. The process of regionalisation has the disadvantage of medicalising the natural process of birth which might become an alienating experience. The authors stated the 1975 Obstetric Regulations in New Zealand exceeded the attempts of regionalisation in other developed countries and attributed this to the organised and consensual nature of medical practice in New Zealand. The Obstetric Regulations defined levels of obstetric care including guidelines for referral of high risk mothers and sick neonates. Rosenblatt and Reinken claimed the majority of uncomplicated pregnancies could be managed in home-like settings close to the residence of the woman. The authors noted that disadvantages of regionalisation included cost of travel, patients being removed from familiar

surroundings and communities lose an important maternity facility. Large obstetric hospitals were likely to become unwieldy and uneconomic when births exceeded capacity with consequence of alienating both clients and staff.

The legacy of Professor Bonham's investigation into perinatal mortality rates in the 31 hospital boards across New Zealand cemented the regionalisation of maternity services (Board of Health, 1976). However, Rosenblatt et al. (1984) found perinatal results were unambiguous; in every weight group of babies, small maternity units (classified as Level one hospitals) had the lowest perinatal mortality rates. The authors stated that most preventable deaths probably occurred in the more sophisticated Level two hospitals (large hospitals with access to caesarean and level 11 neonatal care service). They concluded that small maternity units were safe and function effectively when these units were securely linked with a larger regional network of care. These findings did not support the closure of a third of rural primary maternity units that were operating in 1970. Closure of units impacted greatly on scattered remote populations with relatively high rates of Māori population. Primary units had served these populations, some who were several hours away from a larger obstetric hospital.

### **Regionalising Maternity Services**

Regionalised maternity services changed maternity care exponentially with far reaching political, cultural and institutional changes. Professor Bonham argued in 1982 for routine referral to specialists of all first-time mothers and all women over 30 years of age. Routine ultrasounds, rupture of membranes, use of episiotomies and forceps became common place in centralised obstetric hospitals. When Bonham raised the issues of the lack of experience of family doctors and lack of facilities in small hospitals, the balance of power shifted once again to an obstetrical view of birth (Papps & Olssen, 1997). Paradoxically, a similar transformation had occurred in the 1930s when the government implemented demands from the obstetrical society.

Further technological advances such as epidural analgesia, fetal monitoring, caesarean birth and specialised neonatal care occurred in centralised obstetric facilities. The availability of epidural analgesia during labour became a point of difference between primary units and large obstetric hospitals. Anaesthetists provided epidural analgesia in obstetric settings only with on-site emergency facilities. Epidural analgesia rose in

popularity due to efficacy in regional analgesia without the woman (and baby) encountering significant side-effects associated with use of opioid medication. With increasing choice, control and consent during childbirth, more women opted to labour in large hospitals, with availability of epidural analgesia. McAra Couper, Jones and Smythe (2012) professed that values such as the normalization of caesarean birth has changed women's worldview. Dombroski, Mckinnon and Healy (2016) asserted that the birth environment has changed from a place of care to that of a market place where consumerism is played out. They therefore advocated for a return to focus on relationships rather than conflicts about the perceived benefit of a medical-led birth space as compared to a home-like space.

### **Enabling, Safeguarding and Sustaining Labour care in Primary Units**

The historical overview was undertaken to trace childbirth from the 19<sup>th</sup> century through to the 1980s in Aotearoa-New Zealand. In respect to my research question, links exist with enabling, safeguarding and sustaining midwives to provide labour care in small (primary) maternity units. The passing of the Midwives Act 1904 enabled certificated midwives to provide labour care autonomously while restricting Class B untrained midwives to practise only under the direction of a doctor. In the first half of the 20<sup>th</sup> century, childbirth continued to pose considerable risk to women due to puerperal sepsis, toxemia and lack of access to antenatal care. Contrary to the belief that the Midwives Registration Act stymied midwives, some used the acclaimed training at St Helens hospitals to showcase their qualification and advertise their association with private maternity homes. While history shows that GPs owned private maternity homes, it appears that in some cases, midwives only sent for the doctor when complications arose. It can be assumed that midwives were confident in their ability to provide labour care. Legislation enabled midwives to be managers of private hospitals, with or without doctor attendance. The flourishing numbers of these small maternity homes between the World Wars suggests that, in the main, such units enabled a place for midwives to practise.

In the early half of the 20<sup>th</sup> century, the regimented training at St Helens hospitals safeguarded midwives intrapartum practice with adherence to aseptic procedure and careful management of complications. Whether birth was conducted at home or hospital, trained midwives abided by the obstetric regulations meaning that care was undertaken

according to aseptic procedure, perhaps with lesser regard for the woman's psycho-social and cultural wellbeing. These factors will be addressed further in the following chapter.

While the place of birth changed from private homes to private hospitals, St Helens hospitals, small maternity units and then large obstetric hospitals, one could argue that a place remains for small maternity units in Aotearoa-New Zealand. It is difficult to ascertain from the literature whether or not small maternity units enabled midwives to practise any differently from those who worked in large hospitals. Dobbie (1990) suggested that conditions varied between hospitals with some compassionate midwives in rural maternity units being more attuned to the need for women to rest. Midwives in St Helens hospitals were acknowledged as proficiently undertaking the conduct of births, particularly prior to admission of medical students and GPs attending 'private' cases.

In relation to whether midwives were sustained by providing care in small maternity units, I propose that these midwives developed ongoing relationships with the women they served. Large families were the norm for many women prior to the use of oral contraceptives from the 1960s onward. The midwives developed working relationships with GPs who attended women at the time of birth. Midwives were charged with calling the doctor neither too early nor too late for the imminent birth. However, Dobbie (1990) claimed that midwives in New Zealand were rarely guilty of 'head-holding', a practice common in the United States where the baby's head was held back by pressure to await arrival of the doctor. It appears that midwives in New Zealand retained the competence and confidence to provide labour care and conduct normal birth with or without doctor attendance.

In the following chapter, relevant literature is reviewed in keeping with the research question for this study. The first part of the literature review describes research evidence in relation to safety. The second section of the literature review considers notions related to enabling and sustaining midwives to provide labour care in primary units.

## **Chapter Three: Literature Review**

### **Introduction**

In keeping with the research question, I will discuss the research evidence and literature in relation to what enables, safeguards and sustains midwives to provide labour care in primary maternity units. In the previous chapter, I presented the history of childbirth in Aotearoa-New Zealand, revisiting the move from birth in homes to birth in primary units and later to large hospitals accompanied by burgeoning technology. In this chapter, I will begin by portraying safeguarding during labour and birth in relation to primary units and care by midwives. First and foremost, primary units need to be considered a safe place for birth in order for the public, consumers, obstetricians and midwives to support these units.

The first part of the literature review examines calculative knowledge – rational, scientific evidence that seems to order and control, reducing things to measurable outcomes. The second section reviews meditative knowing; research that ponders, describes, questions, brings things together as wholes and wrestles with complexity, including relatedness with others (Magrini, 2012). Gadamer (2014) challenged the progressive knowledge that science aims for; “the existence of a physicist who, as the calculator would not be an object calculated” (p. 468). Gadamer asserted that the being of the scientist is important in the positioning of the manner of inquiry.

Meanings of safeguarding have been mentioned in Chapter One; yet further exploration guides this literature review. Safe is defined as free from risk or harm while safeguarding is to protect, preserve and ensure safety of. What do we mean when we ask is labour and birth ‘safeguarded’ in a primary unit? What does the literature reveal about the meaning of safeguarding for those doing the work of providing labour care? Having a shared language and a common understanding of meaning is important for effective practice in a shared world (Smythe, 1998).

Smythe (2010) illustrated the dynamic nature of safety in childbirth where the measure of safety is in the context of time; there is no guarantee for a day ahead, an hour ahead, or a minute ahead that safety will remain intact and unchallenged. Smythe suggested that “Every assessment of ‘safety’ is an objectification which translates a situation into a

number, a comparative measure, a depersonalised report” Smythe (2010, p. 1475). The measure of safety and safeguarding is not organised into a single objective tool that disregards other thinking and experiences including those of the woman, her significant others and the midwife providing labour care. Heidegger (1976) warned of a gulf between thinking and science unassailable by a bridge; a leap is required to reach the foothills of thinking. Heidegger (1976) reminded one of the need to ask questions and seek answers beyond the obvious; to always question further.

In relation to quantitative research, I was part of the *Birthplace New Zealand* study examining outcomes according to birth in large obstetric hospitals as compared with primary unit and home birth (Davis et al., 2011). Data were subject to the process of logical regression and analysis. However, there were steps beyond ordering numerical calculations (calculative knowledge); the New Zealand Birthplace researchers applied their collective wisdom and insight to ask the right questions through the process, to check results with a questioning eye and to remain committed to analysing and further analysing. Quantitative research purports to answer questions in a conclusive way; however, varying methods and interpretations that have effect on outcomes might not be declared. Randomised controlled trials might not be appropriate in maternity settings where consumer rights, individualism and woman’s choice prevail; non-adherence after randomisation is frequently under reported in intention to treat trials (McAra Couper et al., 2010; Welsh, 2013). To adequately account for different measures in differing studies, readers need to work through how the research question has been answered and what were the influences; this is one challenge of doing both science and thinking.

### **The Meaning of Safeguarding Labour in Primary Units**

In beginning a review of the literature and safety, it is important to discuss the quantitative studies that hold their place in guiding maternity care, in relation to primary units and midwifery care. The Birthplace in England Collaborative Group study arises as a landmark prospective cohort analysis that compared outcomes and interventions in labour by planned place of birth at the start of labour care for 64,538 low-risk women in the United Kingdom (Brocklehurst et al., 2011). Outcomes for planned birth at home, in freestanding midwifery units and alongside midwifery units (midwife-led units on a hospital site with an obstetric unit), were compared with planned birth in an obstetric unit. The primary research outcome revealed a composite of perinatal mortality and

intrapartum related neonatal morbidities (including stillbirth after onset of care in labour, early neonatal death, neonatal encephalopathy, meconium aspiration syndrome, brachial plexus injury, fractured humerus or clavicle). The authors reported that 3% of births in 2007 in England occurred in alongside midwifery units, less than 2% in free standing midwifery units and home births were 2.8%. For women having their first baby, the odds of the primary composite outcome was higher for planned home births (adjusted odds ratio (OR) 1.75, 95% confidence interval (CI) 1.07-2.86), but not for multiparous women planning homebirth. In contrast, odds of the primary composite outcome were not higher for nulliparous (first time mothers) or multiparous women planning birth in either freestanding or alongside midwifery units. The authors concluded that healthy women with low-risk pregnancies should be offered a choice of birth place with a caution that planned homebirth had poorer perinatal outcomes for first time mothers.

Further data from the Birthplace in England study were used to examine secondary outcomes of interventions; women who planned birth in freestanding midwifery units were significantly less likely to have ventouse, forceps, intrapartum caesarean births, augmentation, epidural/spinal analgesia, episiotomy and active management of third stage of labour. The women were significantly more likely to have a normal birth, defined as birth without induction of labour, epidural/spinal analgesia, general anaesthesia, forceps, ventouse or caesarean section. The proportion of women classified as having a normal birth varied as follows; “58% for planned obstetric unit births to 76% in alongside midwifery units, 83% in freestanding midwifery units and 88% for planned homebirths; the adjusted odds of having a normal birth were significantly higher in all three non-obstetric unit settings” (Brocklehurst et al., 2011, p. 3). Almost all maternity related care in England is provided without fee by National Health Service (NHS) midwives and doctors. There are similarities with the publicly funded maternity system in Aotearoa-New Zealand, excepting that the majority of women in New Zealand have a midwife LMC and opportunity for continuity of care.

According to the large Birthplace in England study, women having their first baby in a freestanding or primary unit have no higher odds for composite perinatal mortality or maternal morbidity than women having their first baby in an obstetric unit and lesser odds than women planning birth at home. What factors influence the composite primary outcome to be statistically lesser within freestanding midwifery units? The authors did not propose a direct answer to this question but acknowledged that the midwife-led units

that participated in this study, functioned with clear referral pathways and access to an ambulance service. Transfer rates for first time mothers in all non-obstetric unit settings was between 36-45%, suggesting that over a third of first time mothers will experience transfer in labour to a large obstetric hospital. Normal birth rates were high for women commencing labour in freestanding midwifery units (83%), second only to women planning homebirth and higher than women commencing labour in an alongside unit. The high rate of normal birth in freestanding midwifery units in England, without accompanying poor outcomes, provides evidence that these units are a safe option for place of birth. Sandall (2013) described midwifery units as providing the best of both worlds where outcomes are favourable and maternal interventions are lower than obstetric hospital settings; however, freestanding maternity units have not increased in number in England mainly due to initial cost in launching these units.

Another study on outcomes was conducted by Hutton et al. (2015) in Ontario Canada where midwives provide continuity of care for approximately 10% of women, of which 20% give birth at home. The remaining women receiving midwifery-led care book at hospitals where midwives have access rights (since 1994), similar to the New Zealand model of care. The authors compared retrospective data for 11,493 planned home births with the same number of low-risk women who planned hospital births at the onset of labour. The Ontario provincial database was used to match cohorts of low-risk women who booked for midwifery care between 2006 and 2009. The primary outcome was a composite outcome of stillbirth after the onset of labour, neonatal death from birth to 28 days, or serious morbidity (Apgar score less than 4 at five minutes of age or resuscitation with positive pressure ventilation and cardiac compressions). The authors found the primary composite outcome did not differ significantly by planned place of birth; absolute risk was 0.39% in each group (RR 1.03, CI 0.68-1.55) and findings were consistent for both nulliparous and multiparous women. Women who had planned home birth had lower intrapartum interventions. The authors concluded that planned home birth undertaken by midwives in an integrated health care system resulted in less intrapartum interventions and was not associated with serious adverse neonatal outcomes. Secondary outcomes comparing interventions revealed that women who planned home birth were less likely to have labour augmentation, pharmaceutical pain relief, fewer assisted and operative births and less postpartum haemorrhages (typically defined as blood loss after birth greater than 1000mls or blood loss that causes compromise requiring interventions).



Both groups of women had a high rate of spontaneous vaginal birth, 90.9% for planned home birth and 87% for the planned hospital group (Hutton et al., 2015).

Different criteria were used by Hutton et al. (2015) to define poor neonatal composite outcome as compared to the Birthplace in England study (Brocklehurst et al., 2011). Hutton et al. (2015) suggested that the Birthplace in England criteria for neonatal morbidity potentially contributed to concern for first time mothers birthing at home. In the Ontario study, the normal birth rate is high for both cohorts of women (planned home and planned hospital births) and the authors said a strength of their study is that the same midwives provided care for both cohorts of women, thereby removing the potential confounder of care provider when comparing outcomes. While the Ontario study does not include freestanding birth centres, it reveals positive findings for out-of-hospital births.

Further research for out-of-hospital birth was undertaken by Cheyney et al. (2014) focusing on planned home birth at onset of labour for 16,924 women in the United States; care was provided by midwives and the outcomes generated a benchmark for out of hospital birth. Spontaneous birth rates were 93.6%, assisted vaginal birth 1.2% and caesarean birth 5.2%. The study included women with previous caesarean births. For all neonates in the sample, including congenital anomalies, 1.5% had Apgar scores below 7 at five minutes of age and 0.6% had Apgar scores below 4. The authors concluded that outcomes are congruent with other observational studies that examined intended place of birth and perinatal outcomes, with their study finding high rates of physiological birth at home without increase in adverse outcomes.

A metaanalysis of planned home birth versus planned hospital birth was reported by Wax et al. (2010). Twelve studies of 342,056 planned home and 207,551 planned hospital births from retrospective, prospective, matched cohort and population cohort studies were included. The metaanalysis comprised data collected over a period of three decades; from 1976-1982 for the earliest study while a latter study was from 2003-2006. Findings reported that women who planned home birth experienced significantly fewer medical interventions including epidural analgesia, electronic fetal monitoring, episiotomy, operative vaginal and caesarean birth. Wax et al. reported that perinatal mortality was similar by intended birthplace, however, the neonatal death rate was almost tripled in

planned home birth among nonanomalous babies. The authors concluded that intrapartum asphyxia occurred more commonly in the homebirth group and proposed a link between increased neonatal mortality, decreased obstetric interventions and possible failed resuscitation in the group of planned home births. A greater number of women in the planned homebirth group had pregnancies that progressed to or beyond 42 weeks gestation. Wax et al. (2010) did not state whether a registered health professional was present at home births. While this study reported outcomes for home births, the extensive time-span for data included in the metaanalysis and, lack of analysis regarding attendants (and resuscitation equipment) for home birth women has limited the application of these finding to primary units in Aotearoa-New Zealand.

Another recent study analysed birth certificates, adapted by adding a question asking whether or not the woman had planned to birth at home or in a freestanding birth centre in Oregon, United States (Snowden et al., 2015). It is unclear who provided care for all the out-of-hospital births because the authors commented that licensure of midwives was not compulsory for out-of-hospital births until 2015 in the state of Oregon. The authors compared births planned at freestanding birth centres or at home (n=3203) with planned hospital births (n=79,727) from January 2012 to December 2013. The women were at 37 weeks gestation or more with a singleton cephalic presentation. After transfers were reclassified to home or birth centre, the rates of perinatal and neonatal death were higher in planned out-of-hospital births (perinatal death, 3.9 vs. 1.8 deaths per 1000 deliveries,  $P = 0.003$ ; neonatal death, 1.6 vs. 0.6 deaths per 1000 deliveries,  $P = 0.02$ ). On the other hand, interventions such as induction, augmentation of labour, caesarean (24.7% caesarean for in-hospital planned birth vs. 5.3% for out-of-hospital planned birth) and admission of the baby to neonatal intensive care were higher in the planned hospital cohort. Goer (2016) asked what factors created opposing conclusions on perinatal outcomes between the Hutton et al. (2015) Canadian study and the Snowden et al. (2015) American study? Goer (2016) pointed to the different models of care whereby women who had hospital birth in the American study were more likely to be attended by obstetricians. Both studies concur that planned out-of-hospital births reduce caesareans. The United States has approximately 1% of births occurring in homes and birth centres (Goer, 2016), lower than rates in the England Birthplace study cited earlier. In both Canadian and American studies, maternal risk factors (previous caesarean surgery, diabetes, hypertension) did not exclude them from the study group.

While Australia has different models of maternity care in different States, it is similar to New Zealand in respect to having a centralised maternity system. Homer et al. (2014) reported on the Birthplace New South Wales population based cohort study, undertaken from various perinatal databases and birth registrations. Eight years of data (2000-2008) were obtained from 258,161 full term women and their infants. The primary composite outcome was neonatal mortality and morbidity (same outcome used by Birthplace in England study thus enables comparisons). Women were assigned to planned place of birth with 94.1% planning hospital labour ward, 5.6% planning birth centre and 0.3% planning home birth. Overall, the incidence of the composite primary outcome was not statistically different between groups; however, the primary outcome for nulliparous women in the homebirth group was higher, in similar manner to the Birthplace in England study. While only four babies in the homebirth group had adverse outcome, it is worthwhile noting that two of these infants were greater than 42 weeks gestation at commencement of labour and one infant was greater than 41 weeks. Three of the four babies with adverse outcome were born in hospital as opposed to home birth as planned. Some years ago, Gottvall, Grunewald and Waldenström (2004) found adverse outcomes in a Stockholm birth centre for women post 41 weeks gestation and the authors commented that in the latter part of their 10 year study, guidelines changed to exclude women with gestation beyond 42 weeks from labouring at the birth centre in order to mitigate adverse outcomes.

Returning to the Australian setting, Monk, Tracy, Foureur, Grigg and Tracy (2014) found that women who planned birth at a freestanding midwifery unit were more likely to have a spontaneous vaginal birth with no significant differences in the baby's five minute Apgar score. Babies born in freestanding midwifery units were significantly less likely to require admission to a neonatal unit and women had similar or reduced odds for intrapartum intervention. The findings from this study support the provision of labour care in freestanding midwifery units as compared with tertiary obstetric units. These studies provide a foundation for the examination of outcomes within the New Zealand context.

### **Recent New Zealand Studies on Birth Outcomes**

A New Zealand study undertaken by Davis et al. (2011) focused on care provided by LMC midwives who used the Midwifery Maternity Provider Organisation (MMPO)

database system. With permission from the New Zealand College of Midwives who manage MMPO, data were extracted for births in 2006 and 2007. Of 39,677 births, 16,453 women (41.47%) met the study criteria for low-risk. The purpose of the study was to compare mode of birth, intrapartum interventions and neonatal outcomes for low risk women according to planned birthplace under the care of midwives. Similar to the Birthplace in England study, the majority of women, 70.9% in the New Zealand study, planned to give birth in large obstetric (secondary or tertiary) hospitals. However, a greater percentage of women planned non-obstetric unit birth; 17.7% planned birth in primary units and 11.3% planned homebirth. Findings revealed that the risk of an emergency caesarean (an unplanned caesarean undertaken during labour) for women planning to give birth in a tertiary hospital was 4.62 times that of a woman planning to give birth in a primary unit (95% CI 3.66-5.84). The neonates of women planning to give birth in secondary and tertiary hospitals had an increased risk of admission to a neonatal intensive care unit (RR 1.40, 95% CI 1.05-1.87; RR 1.78, 95% CI 1.31-2.42) than women planning to give birth in a primary unit.

Further findings from (Davis et al., 2011) indicated that women planning to give birth in secondary/tertiary hospital settings were at increased risk of assisted birth (forceps or ventouse), artificial rupture of membranes, augmentation of labour, pharmacological pain management and episiotomy. The authors proposed that women planning birth in primary units and home are likely more motivated toward avoiding pharmacological pain relief and artificial rupture of membranes; however, this does not explain significant differences in the risk of augmentation of labour and caesarean or operative birth for low-risk women commencing labour in a large obstetric hospital. Davis et al. (2011) suggested that midwives who predominantly book women into large obstetric hospitals may be more amenable to intrapartum interventions, although they are not responsible for authorising augmentation of labour or operative birth. Perhaps the availability of interventions means there is a culture of readiness to use such interventions, be they doctors or midwives.

In addition to birthplace and intervention, S. Miller and Skinner (2012) conducted a small study in New Zealand and found that LMC midwives changed their practice when caring for low-risk women according to the place of birth. Participant midwives completed a questionnaire for their most recent low-risk first time mothers who planned to commence labour at home or in an obstetric hospital in Aotearoa-New Zealand. The final sample

compiled 225 low-risk women who commenced labour at term; 109 planned home birth and 116 planned hospital birth. The authors concluded that, in similar manner to other studies, higher rates of interventions occurred in the obstetric hospital such as: artificial rupture of membranes, use of intravenous fluids and an increased number of vaginal examinations. Further, women who planned hospital setting birth were three times more likely to have cardiotocograph monitoring of baby compared to those who planned home birth. The authors suggested that midwives were more likely to apply evidence informed midwifery practice when working in the home setting, for example, by allowing time for labour to unfold and keeping vaginal examinations to a minimum, than when they provided midwifery care in a hospital setting.

Farry (2015) undertook a retrospective cohort exploration of the effect of place of birth on perinatal outcomes; maternal admission to theatre and high dependency unit, maternal blood loss, neonatal unit admission and Apgar score at five minutes. Data were examined for 4,207 low-risk women with a singleton, cephalic pregnancy who had spontaneous labour at one of three primary units or alternatively, at the large tertiary obstetric hospital within Counties Manukau DHB, New Zealand. Findings disclosed that low risk women presenting to the primary unit were four times less likely to have a caesarean birth (OR 0.25, CI 0.157-0.339) and three times less likely to have a baby with Apgar score below 7 at five minutes of age (OR 0.313, 95% CI 0.124-0.791). Farry (2015) concluded that low-risk women who planned birth in primary units were less likely to experience postpartum haemorrhage or admission to high dependency unit and argued that giving choice of birthplace is vital. She encouraged LMC midwives to promote birth outside of large tertiary hospitals.

Exploration of the literature on outcomes for birth outside of obstetric centres reveals little congruence in methods, analysis and findings. Cheyney et al. (2014) commented that difficulty arises when trying to compare birth-related mortality across studies for several reasons; there are few death outcomes in high resourced countries thus statistical power is quite low, studies comparing low-risk women and place of birth have fewer deaths than studies including women of risk and the home and birth centre studies to date show little consistency in the way mortality is defined. Furthermore, confidence intervals are under-reported thus making it difficult to conduct comparison between studies or, conversely, confidence intervals when reported are often large, as with the findings from Farry (2015). All is not lost when confidence intervals are large from studies; this can

serve a purpose of planning for future studies that might reveal statistically significant results with lesser margin in confidence intervals.

### **Safety of Midwife-Led Care**

An important Cochrane review (Sandall, Soltani, Gates, Shennan, & Devane, 2016) compared midwife led continuity of care with other models of care through meta-analysis of 15 Cochrane trials involving 17,674 women. The authors aim was to establish if women and babies do better with a midwife-led continuity model, whereby the midwife is the lead professional from the time of booking, up to and including, early postpartum care, compared with other models whereby an obstetrician or family doctor is the lead healthcare professional. Women who were low-risk of complications and those at increased risk but without problems were included in the study. Four of the trials included in the study offered care in midwife-led units; however, homebirth was not included in any of the trials reported. While this review is not directly related to outcomes according to birthplace, midwife-led care is the predominant model of care in primary units hence has relevance to my study. All primary findings were graded as high quality (Sandall et al.) and are reported in detail below:

Women who had midwife-led continuity models of care were more likely to experience spontaneous vaginal birth (average risk ratio (RR) 1.05, 95% confidence interval (CI) 1.03 to 1.07; participants = 16,687; studies = 12; high quality). There were no differences between groups for caesarean births or intact perineum. For the secondary outcomes, women who had midwife-led continuity models of care were less likely to experience amniotomy (average RR 0.80, 95% CI 0.66 to 0.98; participants = 3253; studies = four), episiotomy (average RR 0.84, 95% CI 0.77 to 0.92; participants = 17,674; studies = 14) and fetal loss less than 24 weeks and neonatal death (average RR 0.81, 95% CI 0.67 to 0.98; participants = 15,645; studies = 11). Women who had midwife-led continuity models of care were more likely to experience no intrapartum analgesia/anaesthesia (average RR 1.21, 95% CI 1.06 to 1.37; participants = 10,499; studies = seven), have a longer mean length of labour (hours) (mean difference (MD) 0.50, 95% CI 0.27 to 0.74; participants = 3328; studies = three) and more likely to be attended at birth by a known midwife (average RR 7.04, 95% CI 4.48 to 11.08; participants = 6917; studies = seven). There were no differences between groups for fetal loss equal to/after 24 weeks and neonatal death, induction of labour, antenatal hospitalisation, antepartum haemorrhage, augmentation/artificial oxytocin during labour, opiate analgesia, perineal laceration requiring suturing, postpartum haemorrhage, breastfeeding initiation, low birthweight infant, five-minute Apgar score less than or equal to seven, neonatal convulsions, admission of infant to special care or neonatal intensive care unit(s) or in mean length of neonatal hospital stay (days). (Sandall et al., 2016, p. 2).

These results show that women with midwife-led continuity of care had a higher incidence of spontaneous vaginal birth (no induction or instrumental delivery) and there was no difference in neonatal death, neonatal convulsions and admissions of neonates to special care baby units. Women receiving midwife-led care were less likely to have an epidural and fewer women had instrumental births. The authors concluded that the review identified no adverse effects compared with other models of care and surmised the probability that “midwife-led continuity models of care are associated with a reduction in fetal loss and neonatal death by approximately 16%” (Sandall et al., 2016, p. 23).

An earlier review by Sutcliffe et al. (2012) conducted from 28 trials of 21,105 low-risk and high-risk participants, over a lengthy period from 1969 to 2003, found no evidence that indicated any risk to neonates by midwife led care compared to physician led care. All trials were from high-income developed countries; Great Britain, Canada, Australia and the United States. None of the reviews presented evidence of risk to women’s physical health. With midwife led care, spontaneous vaginal birth was significantly more likely and regional analgesia and instrumental birth was less likely when compared with physician-led care. There was no difference in caesarean or induction rates between the models of care. The authors concluded their rigorous meta-review revealed that midwife-led care for low-risk women compared with physician-led care reduces the number of procedures in labour and does not pose any greater risk than care led by physicians in predominantly low-risk women. These findings are similar to those of Sandall et al. (2016).

A retrospective cohort study in the Netherlands conducted by Wiegerinck et al. (2015) compared intrapartum neonatal mortality for women starting labour in midwife led primary care and obstetrician lead secondary care. From 83,289 singleton births after 37 weeks gestation (excluding pre-planned caesarean birth, babies with congenital anomalies and antepartum death), findings revealed intrapartum and neonatal mortality rates were similar for those starting labour in midwife-led care with those starting labour in obstetrician-led care. The authors found women who started labour in midwife-led primary care were more likely to give birth spontaneously (86% vs. 72% RR 1.19, 95% CI 1.18-1.20) and had a correspondingly lower rate of caesarean and instrumental births. There was a lower rate of women in the midwife-led care group receiving pain relief by

epidural or non-epidural analgesia and risk of postpartum haemorrhage was lower. Of women who started labour in the midwife-led primary care group, referral to secondary obstetric care during labour was 39%. Women who were transferred in labour remained classified in the primary care group in keeping with research method of intention-to-treat.

These findings by Wiegerinck et al. (2015) contradict findings by Evers et al. (2010) who reported a significantly higher incidence of birth related perinatal death among women who commenced labour in primary midwife led care as compared with obstetrician led secondary care (RR 2.3, 95% CI 1.1-4.8). Wiegerinck et al. (2015) commented that Evers et al. (2010) used a different methodological approach wherein the numerator group of 'cases' was not restricted to postal codes from the region; however, the denominator group (total number of births) was restricted to postal codes in that region. These concerns had been noted by other authors who critiqued this study including Gilkison, Crowther and Hunter (2011). Wiegerinck et al. (2015) acknowledged that changes in maternity referral guidelines had occurred in the Netherlands in recent years to achieve consistent practice and that rates of perinatal mortality had been shown to differ between regions.

A recent New Zealand study found poorer outcomes for midwifery led care that contradicted the large meta-analysis Cochrane review undertaken by Sandall et al. (2016). The study by Wernham, Gurney, Stanley, Ellison-Loschmann and Sarfati (2016) linked data from the initial registration or booking of women with a LMC. A population based retrospective cohort study was undertaken of 244,047 singleton term deliveries from 2008-2012 for women first registered with a midwife, obstetrician or general practitioner as the LMC. Outcome measures included low Apgar score at five minutes, intrauterine hypoxia, birth-related asphyxia, neonatal encephalopathy and mortality outcomes (perinatal related mortality, stillbirth and neonatal mortality). Only 8.5% of all women in the study first registered with a doctor (medical) LMC (predominantly obstetricians because only 1.1% of women registered with a GP in 2012) while 91.5% of women first registered with a midwife LMC. Medical led births were associated with lower odds of Apgar score less than 7 at five minutes (OR 0.52, 95% CI 0.43-0.64), intrauterine hypoxia (OR 0.79, CI 0.62-1.02), birth related asphyxia (OR 0.45, CI 0.32-0.62) and neonatal encephalopathy (OR 0.61, CI 0.38-0.97). The authors stated they were unable to differentiate whether women in the midwife-led group had medical input during pregnancy. Nevertheless, the authors concluded the medical-led group had 55%



lower odds of oxygen deprivation during delivery, 39% lower odds of neonatal encephalopathy that can result in brain injury and 48% lower odds of low Apgar score indicative of infant wellbeing.

Does the Wernham et al. (2016) study point to concern with the New Zealand model of care that is dominated by LMC midwives? Analysis by de Jonge and Sandall (2016) commented that New Zealand is the only high-income country where midwifery led continuity of care has been implemented across the country and rare, severe adverse outcomes can be explored in this context. They noted the study compared 20,662 women, predominantly in obstetrician led care with 223,385 women in midwife led care at the point of registration. How can statistical significance of two such disparate groups in terms of numbers and caregiver be measured? What has influenced the outcomes from this New Zealand study to be markedly different compared to those from the Cochrane review? Is it possible that rare outcomes might have been detected more readily in the New Zealand study than the Cochrane review, or the quality of care offered to women by a midwife versus an obstetrician might be different? It is likely that confounding factors affect findings of an observational study. Critique of the Wernham et al. (2016) study by de Jonge and Sandall (2016) included concern that additional outcomes for mothers and babies were not reported (including births prior to 37 weeks gestation), along with separate outcomes for nulliparous and multiparous women. Furthermore, the model of care should be detailed at the onset of labour. All outcomes reported in the study, apart from stillbirth, were labour related; therefore, to evaluate outcomes of labour care, the appropriate comparison is midwife versus obstetrician led care at the time of labour care commencing. It is likely that many of the women in the Wernham et al. (2016) study had medical input from the onset of labour in a shared care arrangement and women registered in the medical-led group were likely to have midwifery support during labour. Further, it is not possible to draw causal relationships from observational studies. Important differences that were not controlled for included differences in the type of women choosing midwife or medical led care, place of birth and distance from hospital [32 primary units in New Zealand are greater than one hour drive from an obstetric unit] along with unplanned home birth. While de Jonge and Sandall (2016) did not criticise the Wernham et al. (2016) research in terms of quality, they pointed out that high quality studies have a clear description of the models of care, comparison of appropriate groups, outcomes for mother and infant and adjustment for potential confounders and subgroup analysis such as parity.

Along with many others, I worked as a case loading LMC midwife in Aotearoa-New Zealand during the period of time when data were examined by Wernham et al. (2016). There is reluctance by practitioners to change the registration of women to another LMC for many reasons; time and paper work, reluctance by an obstetric team to take on the LMC requirements and the need for a designated LMC to provide home postnatal visits. It is a simpler process for LMCs to transfer clinical responsibility to the obstetric team either antenatally or intrapartum when risk factors arise. The authors did not account for the model of care at commencement of labour and the potential for shared care intrapartum; whereby the obstetrician-led team of doctors carry clinical responsibility for decision-making. When Skinner and Foureur (2010) undertook research on LMC midwives in New Zealand, they found midwives' consultation rate with obstetricians was 35% and of those women, almost one half were changed to clinical responsibility by an obstetrician during labour, without changing LMC registration. While LMC midwives went on to provide labour care for nearly three quarters of the women in Skinner and Foureur's study, this was in a shared care arrangement whereby the clinical responsibility was deemed to be held by either the public funded obstetric team or a private obstetrician. Transfers are an additional factor in the complexity of who holds clinical responsibility. The LMC midwife from a primary unit might hand over all clinical responsibility for the woman on arrival at the secondary/tertiary hospital.

## **Transfers**

Transfers from primary units to secondary/tertiary obstetric hospitals are part of the safety network when women in labour change from being low-risk. From the Birthplace in England study, transfer rates were higher for first time mothers at 36-45%, compared with 9-13% for multiparous women (Brocklehurst et al., 2011). Cheyney et al. (2014) reported that, in the United States, 11% of women who planned homebirth at onset of labour were transferred but did not differentiate number of first time mothers and number of multiparous women. In Australia, Homer et al. (2014) reported that 29% of women were transferred from the New South Wales birth centre and 18.6% transferred from home; of these, nulliparous women had 32.3% transfer rate, while multiparous women had 8.7% transfer rate. The study by Grigg, Tracy, Tracy, Schmied and Monk (2015) was undertaken at the time of major earthquakes in the region of Christchurch, New Zealand that caused a quarter of women to change from primary unit to tertiary hospital.

For women who commenced labour in the primary unit, the transfer rate was 12.6% with almost all being women having their first baby. Grigg et al. (2015) noted that primary units are often perceived to be unsafe due to the time required for transfer. However, in their study, most women who required a change in planned birthplace undertook this change prior to entering the primary unit. This reflects skilled assessment by midwives in the woman's home and their capability to successfully triage women according to guidelines.

## **Part Two of Literature Review**

In the second part of this literature review, I move from the focus on scientific quantitative studies regarding safeguarding and midwifery care to notions of what enables, safeguards and sustains midwives to provide labour care, what 'works' in primary units. Downe and McCourt (2008) proposed that practice, research and policy development in a maternity service be guided by "the concept of salutogenesis, or the generation of wellbeing" (p. 20). This concept moves away from a focus on outcome measures of morbidity to the 'salutogenic' positive aspects of a woman's clinical, emotional, social, spiritual and family health that might point to having a normal birth in a midwifery-led freestanding unit (or home). The authors believed that wellbeing is maximised by a salutogenic approach to birth; acknowledging the synergy of woman, baby and family and maximising the opportunity for normal birth (Downe & McCourt, 2008). Few studies to date have adopted a salutogenic approach to measuring outcomes in maternity care (Perez-Botella, Downe, Magistretti, Lindstrom, & Berg, 2015). For women, attributes of care such as being respected, being in control and being listened to are associated with increased satisfaction and possibly contribute to women gravitating to birth at home or using birth centres (S. Fleming et al., 2016). Smythe (2010) noted that the person living the experience of safety during childbirth is the mother; it is her body and her baby, her experience matters. While research on mortality and morbidity according to birthplace dominates media reports, Walsh (2006a) pointed out that a variety of designs and measures are used to obtain such outcomes thus producing inconsistent results. Despite the findings from the large Birthplace in England study that outcomes in freestanding maternity units are safe, Rogers, Villar and Harman (2015) lamented the lack of uptake of women presenting at these units; suggesting there are strong beliefs that obstetric hospital care provides the safest care. Walsh and Downe

(2004) claimed that low-risk women are safer in freestanding midwife led units because of the risk of interventions with increased morbidity for those low-risk women in centralised obstetric units.

Quality of experience enhances safety and midwifery units that support physiological labour and birth resonate with a social rather than medical model of birth (McCourt, Rayment, Rance, & Sandall, 2016). These authors noted:

It would be hard, and probably unhelpful, to try to disentangle which is most effective (care or environment) in reducing interventions and increasing wellbeing. This is because the ability to care and the approach to care are influenced by the environment in which care takes place, and also by staff wellbeing. (McCourt et al., p. 26).

Primary units comprise a package of care and environment that enables midwives to practise in a setting designed to support normal birth and in turn, midwives are supported and sustained in this setting. Walsh (2006a) found that midwives strove to create a homelike ambience, a relaxed and nurturing environment. In a similar manner, women sought the sanctuary of a birth centre away from the biomedical obstetric unit. Women saw their safety in a social model of care whereby midwives provide skilled support toward assisting normal birth (Kirkham, 2003b). Walsh found that midwives intuited a response to the needs of women and he coined the phrase ‘matrescence’ to describe the skills of empathetic actions; such as the midwife who sat on the floor with a young woman in labour to alleviate her fear of becoming a mother and thus supported her to achieve a normal birth in the centre. While women who plan birth in primary units (or at home) might be different to those who plan birth in an obstetric unit, Davis and Homer (2016) suggested that it is unlikely that one’s desire for a normal birth alone is sufficient to impact on the outcome; instead the authors suggested that planned birthplace might have an effect on the physiology of a woman’s labour.

In keeping with the research question, my interest is in the midwives’ experience of providing labour care in primary maternity units and, while the influence of women might indeed be a strong feature, this is beyond the confines of my study. Nevertheless, women choosing to labour in primary units is a precondition to midwives working in these units. Reference to women is therefore inevitable in a literature search about midwives and primary units. In the Dutch birthplace study, Hitzert et al. (2016) stated that women in birth centres scored autonomy, dignity, confidentiality and social

considerations significantly higher than women who birthed in hospitals under obstetrician supervised care. These factors are poignant for midwives to note when fine tuning their skills of working in a dynamic, flexible partnership with women (Benn, 1999; Boyle, Thomas, & Brooks, 2016; Gilkison et al., 2016; Guilliland & Pairman, 1995). How do midwives develop skills to enable them to work in a primary unit? Does working in a large obstetric hospital hone midwifery skills for working in primary units? What is important in enabling and sustaining midwives to work with women in labour in primary units? In this section, I will discuss the following themes: space and primary units, approaches or philosophy, skills required in primary units, keeping birth normal, the ‘problem’ of normal birth, the enabling / limiting paradox, managing transfers and sustaining midwives providing labour care.

### **Space and Primary Units**

There is a limited body of knowledge about how midwives work in primary units. Rayment, McCourt, Rance and Sandall (2015) suggested that not all midwives have the skills required to support normal birth, despite an assumption this is customary. In a similar manner, Stone (2012) suggested that midwives be trained to work in birth centre settings because the context contrasts markedly with obstetric hospital labour wards. In primary units, midwives pay attention to ‘softer’ aspects such as the ambience of the environment, attention to privacy and reduction in light and noise (Davis & Homer, 2016). While all practising midwives are subject to the same clinical skills and similar guidelines for practice, ‘place’ has an effect upon midwives. The space of birth is important to generate feelings of comfort and a place that facilitates the passing of time; when an environment is calm, midwives are calm and the combination is conducive to women having less analgesia and physiological birth (Foureur et al., 2010; M. Hunter, 2003). Birthing units are associated with increased autonomy for midwives, thus enabling midwives to practise ‘being with’ women in this setting. McCourt et al. (2016) described a midwifery led unit as an enclave and a protected space where midwives felt more relaxed and support is shared.

The environment is also known to have physiological effects on one’s body with the neuropeptide oxytocin reported to have an effect upon a person’s emotional and social behaviour (Hammond, Foureur, Homer, & Davis, 2013). This is relevant for midwives working in birth settings. When midwives perceive the birthplace as calm, supportive

and friendly, oxytocin is released and the authors proposed that midwives are able to conduct midwifery practice in an emotionally sensitive way with the environment enhancing connectedness to colleagues and clients. Midwives adapt their behaviour according to space where homelike domesticity fosters a sense of personal safety, consciously and sub consciously for women and midwives (Mondy, Fenwick, Leap, & Foureur, 2016). Similarly, midwives might feel more confident practising in a different manner in the space of a primary unit such as encouraging women to avoid lying on the bed, working with women on the floor, on birth balls or in the shower room (Townsend, Fenwick, Thomson, & Foureur, 2016). Furthermore, the design of birth rooms needs to consider the effect of bound/unbound space upon the fear cascade of labour while being mindful of individual need of each woman; midwives need to read the situation for each individual and guide the woman through her labour to a space that evokes comfort and security (Stenglin & Foureur, 2013).

### **Approaches or Philosophy**

The approach or congruence of philosophy appears to be a fundamental factor that enables midwives to practise in primary units, alongside their effective working relationships and their achievement of positive outcomes from their work (Edmondson & Walker, 2014; Helberget, Fylkesnes, Crawford, & Svindseth, 2016). Laws, Lim, Tracy, Dahlen and Sullivan (2011) found two philosophies were rated as very important by birth centre respondents; commitment to normality of pregnancy and birth and providing midwife-led care. A phenomenological study undertaken by Bedwell, McGowan and Lavender (2015) found that midwives' confidence is dependent upon the environment, with one midwife stating she needed a year of working in the midwife-led unit before becoming confident that women could give birth normally and to change her stance from a problematic approach to one of a normal approach during labour care. The authors commented that some midwives expressed lack of confidence in low-technology environments after working in high-technology units that adopt a technocratic model.

The perplexing question is whether experience in large hospitals where midwives gain skills related to a wide range of complications helps or hinders the preparation of midwives to function in low technology primary units? Rogers et al. (2015) found that midwives had difficulty accessing and accepting new evidence that is different from previous held beliefs, including that birth centres are safe, if not safer, than obstetric units

for low risk women. Midwives often influence women and their partners regarding their choice of birthplace (Borrelli, Walsh, & Spiby, 2017). For midwives who have limited experience in primary units, facilitating labour care successfully is very important in creating trust in self, engendering confidence and competence in providing care in this setting. Rogers et al. (2015) remarked on midwives' astonishment upon learning that the Birthplace in England findings were contrary to media reports that over-stated the risk of home birth and negated positive aspects of birth centre care. Midwives need to be informed of the significant difference in interventions in obstetric units compared with primary units and the ongoing effects for women after caesarean and operative births.

### **Skills Required in Primary Units**

From my master's research that explored the differences between providing care in primary units and large obstetric hospitals, I developed the following list of skills required to work in a primary unit:

- Being confident in providing intrapartum care in a low-technology setting;
- Being comfortable using embodied knowledge and skills to assess a woman and her baby as opposed to using technology;
- Being able to let labour 'be' and not interfere unnecessarily;
- Being confident to avert and manage problems that might arise;
- Being willing to employ other options to manage pain without access to epidurals;
- Being responsible for outcomes without access to on-site specialist assistance;
- Being confident to trust the process of labour and to be flexible with respect to time;
- Being a midwife who enjoys practicing what the participants call 'real midwifery' (M. Hunter, 2000, p. 143).

These skills were identified from stories told by 10 midwives about how their experience in primary units was different, how it afforded them the opportunity to grow their trust in women's ability to birth and to feel they were enacting their midwifery skills more authentically. Midwifery autonomy is likely to be enhanced within birth centres because time restrictions on labour and birth are more flexible in order to accommodate women's

wishes for physiological birth (Walsh, 2006a). Walsh further proclaimed that freestanding birth centres 'subvert' the rigid timeframes and modernist ethos of large obstetric hospitals. It seems there is 'time' to be attuned to the unique playing-out of each woman's labour.

The notion of practising 'real midwifery' is echoed by McCourt et al. (2016). Midwives used this phrase to describe their practice of supporting physiological birth and they felt more valued as professionals when practising in a birth centre context. However, practising 'real midwifery' is not exclusive to midwives in primary units. Newton, McLachlan, Forster and Willis (2016) reported 'real' midwifery being prevalent among case-loading midwives who enjoyed greater autonomy, establishing relationships with women and practising across the scope, mastering an array of different skills. The skills articulated by M. Hunter (2000) were described by Kirkham (2003a) as "strikingly different from the usual lists of midwifery skills or competencies, though one competency includes the emergency skills which are so necessary for isolated practice" (p. 256). Kirkham suggested these skills are fundamental yet invisible and inclusive of the midwife's self or use of self, rather than specific job-related skills. Similarly, de Labrusse and Kiger (2013) suggested that these skills tend to be associated with relationships that are not narrowly defined and, while all skills were ranked as important by midwives, the ability to avert and manage problems and to let labour 'be' were ranked as most important. Midwives in the rural Scotland study conducted by Harris et al. (2011) felt fulfilled from using all their skills in a midwifery led unit and felt obliged to keep these skills honed in order to be self-reliant.

McCourt, Rayment, Rance and Sandall (2012) explored midwives' readiness to undertake care in different settings and found notable differences for those working in freestanding midwifery units where there are no buzzers to summon obstetric assistance and where midwives relied on their own confidence, skills, and support from their colleagues. Participants acknowledged that freestanding units have more experienced midwives who work within guidelines and that the midwives have good relationships with consultants; all features that contribute toward safety. Working in birth centres is strongly associated with participants supporting normal birth and having self-efficacy to manage difficult situations (Crowther & Smythe, 2016; Zinsser, Stoll, & Gross, 2016). A survey conducted by Kruske et al. (2016) of 17 rural primary units in Australia reported a high level of skill and experience was required by clinicians alongside confidence in



their own skills in order to work in primary units. Only six of the units provided an opportunity for midwives to work as LMCs with the majority functioning with midwives on rostered shifts and GPs responsible for births.

Working without specialist obstetric and paediatric support is a common theme described by Harris et al. (2011). The authors noted midwives needed to cope with emergencies and the only assistance available from specialists was via telephone contact; they described this accountability because the 'buck stops here'. To this end, midwives stated they required additional skills to manage obstetric emergencies and these could be acquired through training courses such as Advanced Life Support in Obstetrics (ALSO) and neonatal courses. These rural midwives felt driven to upskill in order to manage emergencies at distance from specialist support. In turn, the narratives from midwives resonated with themes of responsibility, decision-making skills and confidence. Midwives need to be able to make decisions quickly and have sufficient confidence to staunchly stand by their decisions. They recognised the need for workshops on normal birth and the need to feel confident in primary unit settings. Experienced midwives, assisting midwives with lesser experience in providing labour care in primary units, were recommended to enable more midwives to practise in primary units (Rayment et al., 2015; Rogers et al., 2015; Skinner & Lennox, 2006). Skinner and Lennox challenged New Zealand midwives toward personal action in supporting primary units for intrapartum care.

### **Keeping Birth Normal**

Normal birth has various meanings on a continuum from completely natural to that which entails interventions depending on the setting in which midwives practise (Thompson, Nieuwenhuijze, Low, & de Vries, 2016). Davis-Floyd (2011) noted that birth outcomes are better when practitioners do not interfere unnecessarily. She described midwifery-model-of care practitioners as relying on physiologically and emotionally supportive strategies (upright positions, acupressure, visualisation) and applying watchful vigilance. In cases of minor delay with progress, she suggested position changes, emotional support, massage, immersion in warm water and changing the energy to create more trust as low-tech interventions. How well midwives are enabled to practise normal birth depends upon support for the midwife and the culture of the environment. Midwives who work in a hospital led model of care need to employ additional effort, strategies and

emotional energy to work toward promoting normal birth (Carolan-Olah, Kruger, & Garvey-Graham, 2015; Spitz, Sermeus, & Thomson, 2013). Midwives might well be hampered with regard to enabling physiological birth within the time pressure of obstetric led hospitals unless there is a strong midwifery culture that fosters and sustains physiological birth (Davis & Walker, 2010; Earl & Hunter, 2006; Keating & Fleming, 2009; Mead, 2008).

Is it easier for midwives in primary units to keep birth normal? Darling (2016) explored keeping birth normal through midwives working with a preceptor in either a birth centre or an obstetric unit and found that midwives felt more able to develop skills in reducing unnecessary interventions when working in the birth centre. Stone (2012) conducted a study in a Berlin birth centre and similarly found midwives held a strong belief of supporting normal birth without interventions on the basis that one intervention often leads to further interventions. However, the midwives employed what they considered were gentle interventions, such as hydrotherapy, homeopathy and acupuncture to assist women during labour. One participant described women as being like a caterpillar's cocoon that closes when the woman quietly works with her labour then, like the cocoon, opens as a different form of the same being when she gives birth and transforms to mother with baby. Stone (2012) observed that the measure used to assess progress of labour is open to interpretation and variation; cervical dilatation and progress of labour is judged in conjunction with the woman's behaviour, her sounds and her own pain assessment. As labour progressed, the midwife's voice became increasingly important to the woman; each midwife emphasised the normality of what was happening to the woman, followed by a physiological explanation as to why pain was intense, why baby's heart beat changed, or why a 'show' was present. The midwife's dialogue was akin to a detailed medical explanation and these explanations affirmed the authority and legitimisation of the midwife's work and, furthermore, these explanations were welcomed by women. Reassuring the woman and partner (or significant others) during labour of normality provides reassurance that they are in the right space for normal birth. Walsh (2007) noted that midwives in a birth centre honed the space to maximise the potential for normal birth and that safety for women encompassed a psychosocial dimension.

## **The ‘Problem’ of Normal Birth**

Criticism has often been directed at midwives for excessive emphasis on normal birth with Dietz and Campbell (2016) blaming ideology against caesareans as a reason for unnecessary harm to mothers and babies in one birth centre in the United Kingdom. In contrast, Christensen and Overgaard (2017) proposed that freestanding midwifery units show potential for reducing first time caesarean birth without compromising safety for low-risk women. The availability of one-to-one individualised women-centred midwifery care in a birth centre was viewed by women as a feature that ensured safety (Borrelli et al., 2017). Walsh and Downe (2004) maintained that midwives practising in birth centres are highly skilled with an astute awareness of normal labour and are diligent in updating skills for emergency care. They proposed that it might very well be the midwife’s belief in physiological labour, especially for first time mothers, that enables such women to achieve normal birth in birth centres.

When exploring the concept of ‘watchful waiting’ during labour, Carlson and Lowe (2014) reported that doctors and midwives with past experience of a poor outcome may influence future labour management without the practitioner being aware of the consequences. Ongoing anxiety can have a potent effect upon practitioners with little experience or understanding of low risk pregnancy and birth. Such anxiety is likely to influence practitioners against supporting labour care in primary units. On the other hand, midwives who have experienced ‘good’ outcomes after long labours, might be inclined to continue supporting a woman in a primary unit.

## **The Enabling / Limiting Paradox**

The literature points to ways in which midwives are enabled to work in birth centres and also the things that limit such practice. Midwives in an Australian birth centre accepted the need for guidelines for practice, yet lamented limitations on women who could utilise the birth centre. They valued the weekly meetings with the obstetrician (Edmondson & Walker, 2014). Laws et al. (2011) similarly reported limitations with Australian birth centres not accepting women with previous caesarean, obesity and post-term pregnancy; however, the authors noted variation in the 16 birth centres. In a New Zealand study by Skinner and Maude (2016), the professional context was described by a midwife as managing medico legal risk, including transfers and adhering to guidelines, while forming good relationships with obstetricians helped one’s practice. There appears to be

tension related to the perceived restrictiveness of guidelines, yet the same guidelines provide some relief for responsibility in western society concerned with knowing who is responsible. Guidelines that appropriately lead to safe midwife led care, along with supportive collegial relationships were noted as essential by McCourt et al. (2012) in the Birthplace in England study. These authors concluded that freestanding midwifery units need experienced midwives, good guidelines, good relationships with consultants and good referral processes.

### **Managing Transfers**

In addition to the research reported in the first part of this literature review, transfers are associated with primary unit midwives experiencing anxiety, varying levels of support on arrival at the obstetric hospital and anger and frustration when colleagues challenge their clinical decisions upon transfer (Harris et al., 2011; Kuliukas, Lewis, Hauck, & Duggan, 2016; Patterson, 2007). Tertiary hospital midwives might not appreciate a cautious approach or early labour transfer to avoid dealing with risk in the rural unit. Harris et al. (2011) and Patterson, Skinner and Foureur (2015) noted that rural midwives' decisions to transfer take into account the woman's wishes, colleague's recommendations, local geography and traffic and weather reports, with the latter authors commenting that the timing of the transfer is crucial to the community interest. Transfers might not be possible due to snow or weather in remote regions of New Zealand and Calvert (2015) found these remote rural midwives had to be confident to manage situations within a concept of 'being ready' for whatever might eventuate.

### **Sustaining Midwives Providing Labour Care**

Being sustained is essential when providing labour care in a primary unit and in order to function effectively in any work environment. Crowther and Smythe (2016) explored the context of rural maternity care in New Zealand sifting out what sustains rural practitioners at least an hour away from large obstetric hospitals. Supportive and strong congenial relationships enhanced sustaining, while discord and arguments created anxiety and unrest. The authors suggested that practitioners need to adopt a mood of cooperation and collegiality beyond individual beliefs and professional groups to sustain their work and themselves (Crowther & Smythe). Life-work balance is likely a universal theme for sustaining and Edmondson and Walker (2014) found that birth centre midwives valued like-minded supportive colleagues. Donald, Smythe, and McAra

Couper (2014) described a rural midwife who employed locum midwifery cover to sustain her to continue her work.

Hendry (2009) found challenges in the workplace of rural midwives in New Zealand that threatened sustaining. Some midwives were kept waiting up to three or four hours for an ambulance transfer and when the ambulance arrived, a driver was often the only personnel. This resulted in the midwife being alone in the back of an ambulance and left to manage any emergency during transfer of a woman. Lack of cell phone cover left midwives feeling isolated and the costs associated with locum midwife cover, along with midwives attending their own educational updates, were viewed as un-sustaining. These findings were echoed by Crowther and Smythe (2016) who described rural midwifery care as an 'expensive hobby' with the need to carry additional emergency equipment and midwives having to find transport back to their own vehicle after undertaking ambulance transfers.

A study into the Warkworth birthing centre in New Zealand showed that midwives are sustained by their colleagues and a community who value the birth centre (Smythe, Payne, et al., 2009). LMC midwives in New Zealand who practise in various settings were sustained by working in partnership, reciprocal supportive relationships, like minded midwifery partners, realising that one is not indispensable, managing practice arrangements, generosity of spirit and negotiating boundaries (Gilkison et al., 2015; M. Hunter et al., 2016; McAra Couper et al., 2014). Workplace resilience was explored by B. Hunter and Warren (2014) who found that optimism, confidence and a pragmatic, adaptable response to difficult situations assisted midwives' personal resilience; skills that are surely needed for midwives providing labour care in primary units. Furthermore, resilience is bolstered through midwives feeling they have autonomy in their work, self-efficacy, self-awareness and professional identity including a sense of belonging; love of the job appears to sustain midwives (Crowther, Hunter, et al., 2016).

In contrast, Young, Smythe and McAra Couper (2015) researched burnout and uncovered at the heart of burnout is a sense of individual powerlessness that is shown in loss of joy, loss of passion, loss of family and friends and the inability to restore the erosion of oneself. While these findings might have congruence for primary unit

midwives, the authors did not separate data according to the midwife's predominant work place; this is complicated by the fact that many LMC midwives follow their client's choice of birthplace, thus will practise in homes, primary units and large obstetric hospitals. However, while there are glimpses of the factors that sustain midwives in various settings and ways of practising, the actual sustaining of midwives providing labour care in urban and rural primary units is not articulated in depth.

## **Conclusion**

The literature points towards birth in primary units, birth centres and freestanding midwifery units being safe for mothers and babies, particularly in environments with a well-developed maternity service that enables safe transfer systems to obstetric and/or neonatal services. On the other hand, critics argue that mortality and morbidity is low in high-income countries thus masking poor outcomes outside large obstetric hospitals. Critics similarly question the ethos of promoting normal birth. Notions of safety and safeguarding are vitally important for enabling midwives to provide labour care confidently in primary units and being supported by midwifery and obstetric colleagues who accept their transfers when required. While I have discussed aspects that enable, safeguard and sustain midwives to provide labour care in primary units, the literature search has not revealed studies that fully encapsulate working with sole responsibility in a freestanding primary unit and the intertwining nature of what enables, safeguards and sustains these midwives, what 'works'. The methodology that guided this study is described in the following chapter.

## Chapter Four: Philosophical Approach

### Introduction

*It is important...we do not deceive ourselves and rashly bypass the pressing questions, on the contrary, we must allow ourselves to become involved in questions that seek what no inventiveness can find.*

(Heidegger, 1976, p. 8).

Becoming involved in 'pressing questions' drew me towards this study and the intertwining notions of, 'what is enabling, safeguarding and sustaining midwives who provide labour care in primary units in Aotearoa-New Zealand?' Heidegger (1976) suggested we might deceive ourselves through rashly bypassing challenging questions; the questions that lead to further questions, the questions unresolved by 'inventiveness' or scientific methods. Heidegger also described thinking as that which is thought provoking and interesting; yet the very thing that is interesting to us, can be overshadowed by something else. How midwives are enabled, safeguarded and sustained to provide labour care in primary units needs describing, revealing and understanding in its fullness. It is too important to be overlooked. Primary units receive attention from journalists, health consumers, health practitioners and some researchers when a tragic outcome occurs. On the other hand, when things are functioning smoothly, there is less interest in primary units and the topic may well be perceived as not particularly important. Exploring the nuances for midwives providing labour care in primary units requires deep thinking, Heidegger directed that we turn towards thinking, reaching out to acquire thinking.

### Heidegger: Philosophy and Politics

Martin Heidegger [1889-1976] was a philosopher who transformed thinking in his writing '*Being and Time*' published 1926 with translations to follow (Heidegger, 1996). He contributed to disciplines such as existential psychiatry, literature, drama, theories of religion and theology (Gelven, 1970). Heidegger might be viewed as a philosopher of mystic, undecipherable language or, on the other hand, may be considered the most relevant critic of metaphysics since Kant, alongside Western thinkers such as Plato, Aristotle, Leibniz and Hegel (Steiner, 1989). In 1919, Heidegger began lecturing at Freiburg University on phenomenology sensitive to everyday life and worked initially

as an assistant to philosopher Husserl (McGrath, 2008). However, Heidegger surpassed his senior with lectures that challenged students; he reignited the thinking of Aristotle and produced the renowned publication '*Being and Time*' which he dedicated to Husserl.

Heidegger's philosophy was influenced by his study of Catholic theology, his turn from Catholicism to Protestantism after marrying his Lutheran wife and his experiences living in the rurality of the Black Forest of Germany. His writing and lectures amount to a vast array of written work and translations. The human personal world does not appear as an object of perception; it is lived through interpretations. Gadamer (2014) stated Heidegger's productivity was in disclosing time as the ground hidden from self-understanding that opens up thinking from the position of subjectivity, an experience that Heidegger called 'being'. Heidegger's philosophical insights were disseminated across the continent influencing French philosophers from Sartre to Derrida (Sheehan, 1988). Yet according to Kaelin (1989), Heidegger underplayed the significance of his discovery of a human being's disclosedness that changed views of ontology in the 20<sup>th</sup> century.

Although Heidegger is acknowledged as a great philosopher, controversy and tension abound regarding his role in the National Socialism (Nazi) party in Germany and the effect of possibly fascist views on his writing after '*Being and Time*'. For one year, Heidegger was the rector at Freiburg University (considered a political appointment) before voluntarily stepping down in 1934 due to irreconcilable differences. During the Second World War, he then withdrew from politics and lectured on poetry, language and technology. However, despite his claim of relinquishing ties with the National Socialism movement, he did not withdraw his membership. At the conclusion of the war, Heidegger was investigated; his mental health suffered with a 'breakdown' or inability to function and he was admitted to a sanatorium (Sheehan, 1988). Afterward, Heidegger retreated to the Black Forest hut and continued mystical writing about the unity of earth, sky, mortals and divinities while discussing philosophy with his followers (McGrath, 2008).

Further questions arose about Heidegger's politics when his philosophical black notebooks written from 1931-1941 were published in 2014. This was then followed by publication of notebooks spanning to 1976 (Fuchs, 2015; Trawny, 2015). Purportedly,



Heidegger had wanted the 34 notebooks be published once all 102 volumes of his Collected Works (Gesamtausgabe) were printed; but this wish was not fulfilled (Escudero, 2015). These publications renewed interest in the 'Heidegger Case' dating back to the 1980s when Derrida, Farías and others debated Heidegger's entanglement with the Nazi party. Accusations of anti-Semitism were directed at Heidegger for his writing pointing to the Jewish religion, calculation, machination and technology; all considered responsible for destruction of being and human essence. Rockmore (2016) concluded that Heidegger, along with other philosophers, expounded theories that pose as ahistorical but cannot be reduced or separated from the historical context. Nevertheless, Rockmore proposed a mandate to reject Heideggerian aspects associated with National Socialism in order to 'save' acceptance of other aspects.

Conversely, Babich (2016) argued that Heidegger's writing is in context of world-history, anti-Semitic historic claiming that, despite this discourse, Heidegger supported various Jewish academics years after his resignation as rector of Freiburg University. Babich posed the rhetorical question of whether we expect nothing less than heroism from Heidegger the philosopher, assumed as a 'good' man. Should Heidegger have had foresight to make the right choice risking everything? For a renowned person, resigning from National Socialism might have meant dire consequences not only for himself, but also his family.

How are claims of Heidegger's affiliation with the Nazi party and counter claims able to be reconciled by the reader? What did Heidegger mean in his writings and lectures? Sheehan (2001) asserted that neither students nor professors would volunteer to undertake an exam in translating Heidegger's language into plain English. This raises the possibility that textual translations may not always be accurate. Furthermore, Sheehan probed, how would a right answer be distinguished from a wrong answer?

Thus questions remain about the incompatibility between humanism and Heidegger's allegiance with the Nazi party. While Steiner (1989) contended that Heidegger's muteness of the Shoah (Holocaust) post-1945 was of concern, he expressed bewilderment for errata and inaccurate translations related to Heidegger's work. In a similar manner, Escudero (2015) confirmed that existing documents render different interpretations, pointing to the fact that Heidegger was extremely critical of racist or biological anti-Semitism. Notwithstanding Heidegger's writing on the perils of

modernism, calculation and technology was deemed by Escudero as anti-Judaism. Sheehan (1988) praised Farías for raising awareness of Heidegger's erring and urged us not to stop reading Heidegger, but to continue reading his thinking in a critically enquiring manner. I concur with Sheehan's viewpoint acknowledging Heidegger's philosophical legacy while being mindful of the play between a philosopher's thinking and responsibilities towards humanity.

## **Gadamer**

Hans-Georg Gadamer [1900-2002] built from Heidegger's concepts through his book '*Truth and Method*' published in 1960. Gadamer was credited with insight relating to implementing the process of testing and using hermeneutical methods (Kaelin, 1989). Gadamer concurred with Heidegger, his mentor, who defined understanding as the practical know-how and skills. Gadamer furthered the notion of understanding as that which entails pre-existing concern and the ability to derive a certain meaning from a situation. This expands the Heideggerian notion of concerned existence where preconceptions are attributed to 'Dasein' or being-in-the-world (Dostal, 2002). The philosophical origins of Gadamer's notion of understanding entail a cognitive, practical and linguistic element. In German language the word for understanding (Verstehen) is used in the sense of a practical ability (Gadamer, 2014). Gadamer proposed that a person projects himself toward understanding a meaning where the gathered understandings give new intellectual freedom; the possibility of interpreting, seeing new connections, drawing conclusions and being well versed in textual interpretation.

For Gadamer, to understand is universal; it is a science with a set of linguistic rules that one follows and it is always situationally directed at a goal. An understanding of language can be dated back to Plato who described the essence of thinking as a soulful connection where those involved in linguistic process achieve mutual understanding (Palmer, 2007). Gadamer (2014) illustrated the meaning of understanding further as coming to an accord upon translation. The interpreter of a text shares a basic understanding of what the text is about, as opposed to a literal agreement with the content of the text. Gadamer's understanding is grounded in language wherein the words belong to the researcher but are always an attempt to find meaning within the understanding process. Spence (2016), drawing on Gadamerian hermeneutics, recognises that language and meaning are always

in play and points to the element of unpredictability in social interaction through the play of conversation and/or dialogue.

### ***Fusion of Horizons***

Gadamer (2014) saw historical consciousness within a horizon of understanding; the past is seen in its own terms, not in terms of contemporary criteria. Heidegger referred to the fore-structures of understanding while Gadamer discussed prejudices that both enable and limit one's historical horizon or range of vision. Gadamer suggested transposing ourselves into the historical horizon as an essential requirement for hermeneutics; in order to understand an other situation, we must place ourselves in it. Gadamer further explained that the historical movement of human life is never still; the horizon is "something into which we move and that moves with us", thus the horizon is changing for the person. The horizon of the past (historical consciousness) is inextricably part of the present horizon and the anticipated future (Spence, 2005).

Our own past and historical consciousness of understandings shapes our fluid present horizon. Gadamer (2014) said we test our prejudices in understanding the tradition from which we originated; "understanding is always the fusion of these horizons supposedly existing by themselves" (p. 317). Understandings become a scholarly endeavour and contribute to the hermeneutical situation through the examination of texts. Tension exists between historical consciousness and the present. Hermeneutical analysis requires the researcher to consciously reveal and question such tensions. Gadamer argued that the hermeneutic approach was to project a historical horizon different from the horizon of the present.

In relation to this study, my historical horizon arises from experiences as a core midwife and LMC midwife; I have worked in primary and secondary/tertiary settings. My understandings must therefore be open to the texts of participants wherein their experiences are revealed. For example, my perception of the obstetrician role was principally considered in the context of risk and sending women to labour in secondary/tertiary hospitals. In light of analysis from participants' data, stories showed examples of obstetricians enabling women to remain in primary units for labour/birth. Thus my understandings were open to new insights. Gadamer described a fusion of horizons that incorporates the preunderstandings of the interpreter, the meanings of the text or other person in conversation (Lavery, 2003). The tension between my historical

assumptions and other understandings shape the fusion of horizons that informs my interpretation.

## **Hermeneutics**

Hermeneutics is an interpretive approach, one that attempts to formalise and describe the meaning of meaning, or understanding of understanding. Heidegger drew from Schleiermacher, Droysen and Dilthey placing hermeneutics at the centre of philosophical concern by proposing that understanding is fundamental to human existence; the nature of being human is to be interpretive (Polkinghorne, 1983). It was Heidegger's lectures (rather than *Being and Time*) that promulgated hermeneutics and gave impetus to further development by Gadamer and later Derrida (Grondin, 1994; Steiner, 1989). Hermeneutics is an interpretive process that seeks to bring understanding and revealing of phenomena or experiences through language which already have social meanings. Through examination of texts (including visuals, art, words, music) human activity is interpreted and understandings are cultivated through language. The focus of hermeneutics is to illuminate the taken for granted aspects of meaning. Heidegger (1996) emphasised the situated meaning of the person in a world; uncovering this experience provides a deeper meaning and creates new understandings.

## ***From Hermeneutics to Hermeneutic Phenomenology***

Existential phenomenology endeavours to describe lived experience with foundation works from Schutz, Hegel, Merleau-Ponty and Husserl; all of whom saw consciousness as a means of describing essential structures that make sense of experience. Husserl dismissed Cartesian dualism and ushered in transcendental phenomenology. As Heidegger's teacher, he anticipated Heidegger would follow his stance on human consciousness. However, Heidegger wrote of consciousness as meaning a formation of historically lived human existence, the historic and space-time of being-in-the-world rather than an examination of consciousness (Polkinghorne, 1983). In writing of the 'transcendental self', meaning the awareness of self and existence in one's external world, Heidegger referred to philosophers Kant and Plato. While Kant declared moral inquiry responsible for the transcendental perspective incorporating one's moral responsibility and freedom, Heidegger differed. He pronounced phenomenology as the 'showing' of the thing rather than Husserl's stance of things availability to intuition.

Heidegger calls us to live through phenomena as opposed to inspecting phenomena. He argued against Husserl's concept of suspending or bracketing one's past time and experiences. Heidegger proclaimed that human experiences are an integral part of our past, present and future understandings (McGrath, 2008). Behind our conscious moment of existence, therein lies an unconscious pre-historic past along with infinite tasks of future interpretations. Heidegger, therefore, asserted that interpretation belongs to the interpreter, accounting for past experience, present state of affairs and upon projections into the future (Kaelin, 1989). Through interpretation, the reader deconstructs texts in order to come to new understandings. Phenomenological research entails staying close to the experience itself (ontological) and already 'being' in the specific situating that is always in flux between what can and cannot be seen (Smythe et al., 2008). Phenomenology is described as a descriptive approach with a focus on human experience as lived.

Gadamer (2014) supported Heidegger's ontological reflection through understandings of Dasein beyond the existent; this interpreting surpassed all previous metaphysics. Heidegger moved beyond transcendental reflection with his thesis that being itself is time. Heidegger's 'being-there' showed the array of modes of existence or human experience. He described what it means for the human being existing in a world; to be oneself, to be neighbour, to care, to be afraid, to have fear. Being in a world takes precedence over the structure of the world in Heideggerian philosophy.

I seek to understand what enables, safeguards and sustains midwives to provide labour care in primary units. My understandings have been played out and extended through interpreting the data of participants. Interpretations will always be mine i.e. that of the researcher, but they will have been enlarged upon through exposure to different understandings that could deepen and enrich previous perspectives. Coming to a place of understanding is always tentative; I am open to further interpretations in order to 'see' new understandings of what is enabling, safeguarding and sustaining of labour care in primary units.

## **Dasein**

The meaning of 'Dasein' is essential to Heidegger's hermeneutic phenomenology alongside differentiating between the 'ontic' (the realm of external beings) and

‘ontological’ (a study of ‘Being’ itself). Heidegger (1996) does not question objects, he turns his mind to man [sic], the only entity for whom being is an issue (McGrath, 2008; Steiner, 1989). Dasein, in the German language, means ‘to be there’ ‘to exist’. Heidegger uses Dasein as the ‘being of humans’ and the entity or person who has this being. Dasein is the being concerned with its own being, its ability to ‘be’ in the world.

Heidegger understood ‘Da’ of Dasein as ‘the open’, meaning the human being is ‘open’ and thus is ‘the thing itself’. Da-sein meaning ‘having-to-be-open’ is of necessity; we cannot not be open (Sheehan, 2001). Sheehan emphasised that Heidegger’s early and late language spoke of being-open as our fate, the way we always already are and Dasein should not be translated as ‘being-there’. There is reciprocity between the essence of being thrown-open and sense-making grounded in openness. For Heidegger, human openness is incomplete, it is always on-the-way; our finitude enables our opening up in the world. Understanding of being is only possible “that there is a ‘there’, a clearing in being, a distinction between being and beings” (Gadamer, 2014, p. 258).

Openness cannot be an isolated and self-contained individual. It is affected by others and engagement; co-openness is the basis for living and working together. It is an interpersonal togetherness (Sheehan, 2001). ‘Dasein-with’ refers to the other/s when more than one person is in play. No human being exists in a cultural world alone; being-with is a component of worldhood. Heidegger described modes of concern and circumspection as awareness of the existence of others (Kaelin, 1989). Being in the same world with others ontologically has multiple interpretations; taking care of, being concerned with and caring for etc. The others are mostly those who are there in our worlds by what they do. The midwife in the primary unit encounters others in the world of providing labour care. The woman/family might reassure the midwife through choosing the place/space of a primary unit. Ideally the midwife’s colleagues provide support during labour care rather than showing indifference. If the midwife needs additional help, this is forthcoming in care.

Being-in-the-world is one’s situatedness in the world including historicity; the person’s history, background, culture and understandings, including others. Thus to be a midwife in a primary unit is to be open to whatever is happening ‘now’, thinking ahead to concerns that might loom in the future, remembering similar situations and all the time being caught up in the dynamic play of the unfolding event.

### ***Fore-Structure/Pre-understandings***

Heidegger's fore-structure entailed a forehaving, a foresight and a foreconception. Forehaving has meanings of confidence; in the primary unit context, the midwife knows how to manage the woman bleeding from experience of having coped previously. Foresight entails anticipating; the midwife expects that the woman will labour well. Foreconception refers to understanding of a concept from our previous involvement; for example, the understanding of risks associated with an obstructed labour entails theoretical thinking. The experienced midwife is thinking during a long first or second stage, could an obstruction be stalling this woman's labour? According to Gadamer (2014), all understanding is interpretive. Every encounter involves an interpretation that is influenced by the individual and his/her historicity. Heidegger (1996) similarly said that all the 'things' and events in our life-world are already interpreted through our understanding "as" things that are related to use; the hermeneutic 'as' is an interpretive fore-understanding inherent in Dasein. Grondin (1994) stated the 'as-structure' is pre-linguistic, it is part of our behaviour and is fundamental to everything that engages us. We open a door 'as' a means of entering or exiting. In the context of this study, a midwife opens a birth pack 'as' preparedness and readying for an imminent birth, counting the fetal heart rate in labour 'as' a means of assessing fetal wellbeing.

### ***Spatiality and Temporality***

Heidegger (1996) wrote that "being-in designates a constitution of being of Dasein and is an existential" (p. 50). For Heidegger, being-in has meaning to dwell, to be near, to be familiar with and is relational to Dasein. Heidegger provided an ontological example of spatiality when he described the 'closeness' of a friend approaching us on the footpath; objectively the footpath is closer than the friend, yet we feel no awareness or closeness to the footpath. Dasein's spatiality is in the world and depicts 'felt' space that does not correspond with formal or objective space (Gelven, 1970).

In phenomenology experience, as previously stated, is always temporal as well as spatial. Temporality refers to living simultaneously in the present, influenced by the past and looking to the future. Our way of being involved in the world and making sense of things is relational to making sense of things through self-interpreting that Heidegger terms concern or care (Parsons, 2010). Dasein's existence creates time or

sees time; time is grounded in temporality, in concerned time, in awaiting, retaining and acting.

The midwife providing labour care in a primary unit is open-in-the-world of experiencing space-time. The structural building of a primary unit does not provide the experience of space, it is being-in the space, working in the space, interacting in the space that points to felt-space, dwelling and belonging. Time is not only clock-time but includes 'then', 'ago' and 'now'. 'Now' might be the perception of 'taking forever' when waiting for an ambulance to transfer during fetal distress. Time might 'drag' when awaiting for full dilatation because labour has slowed; or rush by when suddenly the birth of the baby is imminent. We do not have awareness in everydayness of temporality and spatiality until it is brought to our attention through Dasein.

### ***The Hermeneutic Circle***

The meaning of 'being' in the world, Dasein takes one into the hermeneutic circle. The circle is described as circular or spiralling inward, where one's past, present and future time influence understandings of being-in-the-world. Heidegger (1996) described the hermeneutic circle in its circular nature of coming to an understanding of meaning. Within this circle is the fore-structure of the researcher that influences interpretations. The circle comprises individual parts that constitute the whole. The researcher moves from the influence of one's own fore-structure to acquiring insight into parts of the participants' experience of the phenomenon being researched. The researcher moves back and forward between meaning of parts and the whole with an awareness of one's own fore-structure. Similarly, an individual word is understood within the context of a sentence and the sentence is understood through the meaning of individual words (Gadamer, 2014; Spence, 2016). The stories of participants reveal parts of the phenomenon contributing to the hermeneutic circle. The depth of understanding is heightened by the process of delving deeper into understanding the parts which gives a greater understanding of the whole (Laverty, 2003).

Thus, an assessment of a woman's progress in labour at a given point in time is taken back to the assessment of the greater whole: her past history, listening to the woman's perspective, indications of maternal/fetal wellbeing, time needed to transfer to the secondary/tertiary setting, skills of staff on site and the midwife's anticipatory thinking.



The decision on how best to respond in relation to the woman's progress arises when the hermeneutic circle of parts and whole is comprehended.

### **Being Drawn to Hermeneutic Phenomenology**

Prior to commencing this study, consideration was given to other methodologies and various lenses for data analysis, including critical theory, feminist hermeneutics and appreciative inquiry. Hermeneutic phenomenology, informed by Heidegger and Gadamer, was selected as the most appropriate means of holding open the research questions to participants and staying open to the direction of possible findings. Hermeneutic phenomenology seeks understanding and interpretation of data to do justice to the voice of the participants and to reflect the meaning of their primordial experiences. It is a methodology that may reveal findings showing social construction or power influences. Hermeneutic phenomenology does not seek to critique power from the outset. This does not presume that the researcher turns a blind eye to issues such as power or gender. The researcher endeavours to remain open to revealing the participants' experience and everydayness, rather than assuming that a particular worldview or discourse, shapes their everydayness.

My initial intention in this study was to use hermeneutics to show understandings of what enables, safeguards and sustains midwives who provide labour care in primary units. In the process of analysing data, it became apparent that the data was richly storied in the manner of working, drawing nearer to the primordial ontology of being-there. Thus I drew further on Heidegger's writings when analysing the participants' experience and their being-in-the-world of providing labour care in primary units.

### **Conclusion**

Hermeneutic phenomenology was selected as most appropriate because I sought to understand what *enables*, *safeguards* and *sustains* intrapartum midwifery practice. I asked participants to bring their own stories from practice in primary units. Each story is an interpretation of their Dasein, being-there, being-open to what mattered in each situation. In turn, I bring my own interpretive lens within the processes of data collection and analysis. The insights that emerge will fuse to provide deeper understanding of this little researched phenomenon.

In the following chapter, the methods used in this study are detailed. The methods are congruent with the methodology; Gadamer's insights into hermeneutic phenomenology are drawn upon to articulate the processes of interpreting data.

## **Chapter Five: Methods: From Philosophy to Using Hermeneutic Phenomenology**

*...phenomenological analysis needs experiential material upon which the reflection can be conducted. If the experience lacks experiential detail, concreteness, vividness, and lived-thoroughness, then the analysis will fail for lack of substance. Thus, the appropriateness of the phenomenological questions, and the experiential quality of the data, are two critical conditions for the possibility of proper phenomenological reflection and analysis.*

(van Manen, 2014, p. 297).

### **Introduction**

In the previous chapter, the philosophical underpinnings of Heidegger's Dasein and Gadamer's fusion of horizons were described. In this chapter, my pre-understandings are expanded further to situate my social and historical existence in the interpretations of the text. Gadamer (2014) stated that there is no understanding or interpretation in which the totality of the interpreter does not exist; rather than a barrier to interpreting, this becomes the centre of a fundamental inquiry. The methods used in this study are described including: commencing the research, obtaining ethical approval, recruiting participants and undertaking interviewing. The methods of crafting participants' transcripts into stories and then analysing these stories are described in detail to show rigour. Throughout the chapter, the interlinking of methods and methodology is focused on answering the question: 'What enables, safeguards and sustains midwives who provide labour care in primary units?'

Hermeneutic phenomenology is a method of questioning and being 'open'. It is not rule-bound by exacting methods. Questioning draws open the possibility of new understandings and further questions to illuminate phenomena (Gadamer, 2014; van Manen, 2014). Phenomenological interpretations seek to reveal experiential accounts where original insights emerge. Writing a phenomenological text is a reflective process upon experiences as they are lived, with the purpose ultimately "to act practically in our lives with greater thoughtfulness and tact" (van Manen, 2014, p. 20).

### **Engaging with Pre-understandings**

I was interviewed by my supervisors prior to commencing participant interviews to make my pre-understandings explicit. The following data describes some of my pre-

understandings related to enabling, safeguarding, and sustaining midwives to provide labour care in primary units:

*I would say to a woman who has had a normal pregnancy, definitely to go to your local primary unit. I think we have enough evidence to say that women without risks do better in that environment; they can get more established in labour, the natural endorphins have been researched and if you put women in a comfortable environment the natural endorphins kick in, and that gives the pain relief effect. They can use the pool which they often can't use in a large hospital. You usually have a lot of time in general with first time mums if you need to transfer, you have less time with multiples. It might be good for a midwife to have a bit of experience behind them. When GPs were doing the births, most of them insisted that women having their first baby went to the large hospital. We actually have the studies that show that women are safe [in primary units]. When all is normal at the start of labour, a woman is four times more likely to end up with a caesarean, if she starts labour in a tertiary unit compared with a primary unit and the baby is more likely to go to the neonatal unit. It's hard work recovering from a caesarean and women don't like being unable to drive and get about.*

These pre-understandings show a belief of women doing 'well' labouring in primary units peppered with research evidence. Yet, there is mindfulness of transfers occurring from this setting. My past experience of working with GPs comes to the fore; many women having their first baby and subsequent baby, if the first baby had an instrumental birth, were directed by their GP to go to a secondary/tertiary hospital. Perhaps midwives educated more recently, after New Zealand midwives gained autonomy in 1990, do not have awareness of the historical 'control' over birthplace. They are less likely to be encumbered with deciding who can and cannot give birth in primary units. From my LMC experience, I am reminded of the difficulties that some women had in recovering from caesarean birth. Being unable to drive and feeling housebound with a new baby had a profound effect on some women's adjustment to parenting. I go on:

*I think the experience and skills of the whole team are way, way better than they used to be. People do drills together, they do courses, first year practice midwives are really well supported by another senior midwife. It is probably safer now than what it was back in the 1980s. It is part of sustainability that they work as a team, the midwives all feel comfortable there or they don't last. Midwives who do not really believe that it is a good place to give birth don't last there, they go and work somewhere else. Generally it is about confidence, experience, belief and working collegially. Some midwives like working with obstetricians on hand and that is a different environment to primary units.*

Again my past is present. My recall of working as a staff midwife in a primary unit in the 1980s is with me in my thinking of 'now' and in future experience. I proclaim that midwives have advanced with skills through emergency drills and updates. Experienced colleagues support first year of practice midwives. I see primary units through a safer lens than in the past. I come to this research with a belief that enabling, safeguarding and sustaining occurs through midwives feeling comfortable, confident and wanting to work in the primary unit setting. Having experience and working collegially also gives rise to a supportive context of practice.

## **Ethics**

Obtaining ethical approval was approached as an opportunity to describe the detail of conducting my study and minimising any potential for harm. Research undertaken in Aotearoa-New Zealand needs to consider Te Tiriti o Waitangi and understand that all research has an impact upon Māori. Moewaka Barnes et al. (2013) identified four priorities for government, community and whānau in relation to Māori research: 1. Ensuring high quality data as a foundation for research. 2. Addressing societal conditions such as poverty, deprivation and meeting needs of vulnerable populations. 3. Supporting mother, baby whānau through services; with an understanding of stress and maternal mental health issues. 4. Improving services for maternal and newborn care including maternal mental health.

I began this research with awareness that primary units are utilised by women of various ethnicities. However, proportionally, women identifying as indigenous Māori ethnicity are currently the highest user group in Aotearoa-New Zealand (M. Hunter et al., 2011; Ministry of Health, 2015). To this end, I read further about the adverse effects of colonisation on birth practice and the health of Māori from past, present and towards the future. I listened, consulted and was guided by those with wisdom and foresight. I felt the responsibility to do no harm through undertaking this study and explored potential benefits for Māori and all peoples from the findings.

As part of the ethics application, I declared that I was an appointed member to the Midwifery Council of New Zealand from 2010 for two 3-year terms. To mitigate potential conflict of interest, I therefore acknowledged my role on this regulatory authority in the information sheet about the study. I asked that any midwife under

investigation by an agency in Aotearoa-New Zealand, such as the Accident Compensation Corporation (ACC) or Health and Disability Commission (HDC) not to volunteer for participation in my study. Furthermore, I stated that I did not wish to discuss events where criticism or complaints arose from practice. Approval for this study was granted from the Auckland University of Technology Ethics Committee (AUTEC 19.11.14 14/364; Appendix A) prior to commencing the processes of recruiting participants and interviewing.

### **Recruiting Participants**

Purposive sampling is congruent with hermeneutic phenomenology. Participants were selected to share their experience, in English, of enabling, safeguarding and sustaining the provision of labour care in primary units. Initially, on my behalf, my primary supervisor contacted midwife managers of primary units (within the AUTEC approved region) offering an opportunity for them to be interviewed and/or to forward the invitation to midwives they believed could usefully inform the study. The midwife manager was also asked to act as an intermediary by giving an information sheet to an obstetrician who provided consultancy services at the primary unit. All potential participants had access to an information sheet about the study. Recruitment occurred through a staged process wherein my supervisor approached midwife managers over a period of time. Those interested in participating responded directly to me through email. The selection of further participants occurred in order of their response to participate in the study.

### **Example/Sample**

In hermeneutic phenomenology attention is given to the word ‘sample’ that stems from the French root word ‘example’ (van Manen, 2014). As previously mentioned, participants were selected for their knowledge in relation to the research question and ability to provide examples from practice experience. In using hermeneutic phenomenology, the rich quality of experiential descriptions is more important to the research question than the sample size. In keeping with this methodology, the number of participants was relatively small, in this case, 14 participants (see Table 1, p. 77). While ‘saturation’ of data is not a phrase coined in hermeneutic phenomenology, the researcher requires a sufficient number of meaningful stories to richly illuminate the phenomena of

interest. Because data collection and analysis occur concurrently the researcher acquires a sense of when ‘enough’ stories have been gathered.

## Introducing Participants

**Table 1: Overview of Participants**

<b>Participants</b>	<b>Number</b>	<b>Less than Five years in practice</b>	<b>Five to Ten years in practice</b>	<b>Ten or more years in practice</b>
Midwife managers inclusive of LMC and core work	4			4
LMC midwives	4	1	1	2
Core midwives	3			3
Obstetricians	3			3

Participants were drawn from the greater Auckland region according to the criteria discussed earlier. Four midwife managers were interviewed; managers retained clinical practice through LMC work and/or core midwifery. LMC midwives were drawn from urban and rural areas; all used a primary unit for labour and birthing for either some or all of their client caseload. Similarly, core midwives were drawn from urban and rural primary units; all had previously worked as LMC midwives within the context of primary units. Obstetrician participants provided consultancy service at a primary unit. This service entails clinics for women who require consultation according to referral guidelines (Ministry of Health, 2012a) and/or referral for other pregnancy-related issues. All participants were women. Their age range spanned approximately thirty years.

## Interviewing

### *Getting Ready for Interviewing*

Setting up interviews can be challenging, particularly when participants provide on-call maternity care, cover for colleagues’ leave, sickness and are on-call for the primary unit. It was essential, therefore, that participants were able to choose the time and venue for interviewing. Through email and/or phone conversation, I indicated consideration for the participant’s privacy when choosing a venue. I informed participants that I would be

using a small recorder, hence a quiet environment was preferable for recording the interview.

I offered to meet participants on days without work commitments, including weekends and evenings. Midwives and obstetricians appear to be under increasing time pressure with being on-call, night work and covering for sickness. Most participants elected to 'fit' the interview into their working day; early morning, end of a work day or during a space without appointments. Some interviews were cancelled due to workload, forgetting the day or personal circumstances. When an interview time had been cancelled on more than one occasion, I gave the potential participant the option of rescheduling or, if preferred, of not taking part in the study. In each instance, the participant was keen to pursue another time for being interviewed. One participant telephoned me before the time of the scheduled interview saying "Come now. I have a gap in my clinic". Periods of time-space were seized to undertake interviews. One practitioner showed initial interest in the study but later declined due to the exclusion criterion of being a practitioner potentially involved in a case under investigation. Prior to conducting the interview, I provided an information sheet (Appendix B), invited questions about the study and ensured the consent form (Appendix C) was signed.

### ***Gathering Data***

The interviews sought to gather and explore experiential narrative material as a resource for phenomenological reflection; but interviewers can overestimate the ease of getting participants to tell their experience in narrative form (van Manen, 2014). I sought stories with detailed description of assisting women to labour in the primary unit. I endeavoured to gather pre-reflective descriptive accounts from participants, avoiding opinions and judgements.

In coming to the interview, I offered to bring coffee/tea and food to create a space for co-sharing and show appreciation for the participant's time. I began the interview by thanking each participant, reiterating the intention of the study and inviting them to describe how they came to work in a primary unit. From there, I invited the participant to tell me stories from their practice experience, for example; "Can you tell about a woman that you encouraged to labour in the primary unit". When required, I offered a prompt to take the participant to another story.



At times during interviewing, I fell into the trap of asking questions that resulted in short answers and opinions. Acquiring actual stories from participants is a timed, timely and time-taking process. Although some participants 'opened up' early in the interview through the telling of coming to work in a primary unit, I needed to ease the participant into the phenomenological interview. Telling a story is stymied when the participant is interrupted by on-call phones, knocking on the door and/or needing to manage unexpected urgent problems. While participants attempted to focus on the interview, the calling to respond to client's needs and/or colleagues' consultation overrides an interview. On occasions, I spontaneously stopped the recorder in order for a participant to speak with a client or colleague. In one case, the participant asked me to stop the recorder knowing that the interruption was not short-lived. In that instance, I offered to excuse myself from the conversation.

Interviewing is a learned art whereby on some occasions stories flow and on others it seems as if no stories are forthcoming. After each interview, I reflected on my approach. Perhaps tiredness was influencing data collection? It may depend on how comfortable the participant feels in the telling the lived-experience. Thus it is essential that the researcher (myself) remain attuned to the mood of the interview, prompting only when required.

Participant stories need to be welcomed with encouraging nods and gestures because these can help participants to expand upon their stories. Smythe et al. (2008) reiterated the uniqueness of each interview where the researcher is encouraging the participant to describe details and trusting the 'play' of conversation. In order to gain data to assist with coming to a greater depth of the phenomena, I mostly used open ended 'how' and 'what' questions (Appendix D).

At times during the interviews, I needed to bring the conversation back to the topic: what enables, safeguards and sustains midwives to provide labour care in primary units; what works? Gadamer acknowledged that questions pre shape and determine the answers; therefore care needs to be taken in what interviewers ask and fail to ask (Palmer, 2007). Keeping the phenomenological intent of the interview clearly in mind and trying to obtain concrete stories of particular situations are the key themes suggested by van Manen (2014) for success with interviewing.

There is an unknowing and unpredictability with phenomenological interviews in that data gathering involves the art of conversing, being open, listening and being comfortable with silence. It takes practice to acquire the style of interviewing. I grew my experience with conducting phenomenological interviewing over a period of greater than a year. Actual recording time of interviews ranged from the shortest being 15 minutes to the longest taking 65 minutes. Most interviews were between 45-50 minutes. Although I typed the recording of my own pre-assumptions interview, this was a time-consuming exercise and I employed expert assistance to transcribe the participants' interviews.

### ***Transcribing and Returning Data to Participants***

Recorded data were shared with the transcriptionist who signed the AUTECH confidentiality agreement (Appendix E). All interviews were transcribed verbatim. If the transcriptionist could not discern particular words or phrase, its time of occurrence was made in the transcript. I would then listen to the interview and enter the missing words or phrases unless the word was known from memory of the interview. The transcriptionist returned transcripts promptly, (often a matter of day/s), thus keeping the interview current and memorable.

With the participants' consent, I returned the edited transcript where I had grouped data into preliminary headings and/or themes. Participants were invited to read the transcript, change or delete any parts and return the transcript. After one participant corrected grammar throughout the transcript, thereafter, I explained to participants via email or letter that they did not need to correct grammar; this would occur when data were edited further into stories for the thesis. Two participants indicated they did not wish to see the transcript and gave permission for everything verbalised to be used in my thesis. All participants had the opportunity to make changes to their transcripts. Below is an example of my correspondence when returning a transcript to a participant:

*Thanks once again for being a participant in my study, I'm returning your transcript. You will see that I have edited the transcript and taken out most of my comments. There are a few section breaks where we paused the tape but then continue on. I have written provisional headings in line with the research question. The way we speak is different to the way we write - please don't correct the grammar as I will attend to this later when including parts of data into the thesis. I am sending this back to you as an ethics requirement, and of course, for your interest. You are free to delete anything you don't want me to use in my thesis, or alternatively, add anything that you wish. If you are happy with the transcript, you don't need to do anything at all. Please feel assured that I will change details further, such as any personal*

*information and place names etc. I have included your pseudonym in the transcript. I hope you enjoy reading through this as much as I did. Warm regards and please accept my gratitude. (Marion)*

In terms of analysis, it is not considered essential in hermeneutic phenomenology to return transcripts and/or stories to participants, however, it may be of benefit to participants (Crowther, Ironside, Spence, & Smythe, 2016). Some participants expressed gratitude after receiving their transcript; one participant said she would use the transcript reflections at her next midwifery standards review<sup>1</sup>. Once participants indicated they were happy for me to use their data changed or unchanged, I began the process of crafting stories. The details of this process are described in the next section.

### **Crafting Stories**

Crafting stories is inherent in methods associated with hermeneutic phenomenology and is argued to be part of the dialectic movement between methodology and methods (Crowther, Ironside, et al., 2016). Data with direct descriptions of the experience provide the best material for analysis. Smythe et al. (2008) suggested that we are often called by a particular story. It claims our attention because it seems to signal or point to something important. While driving, I listened to a radio interview about a collector of art in Aotearoa-New Zealand. The collector described how he felt when called to a particular painting. He described his heart pounding and breathing become more rapid. Furthermore, he described the sense of the artist reaching out of the painting and grasping him around the throat. That is how he knew he could not walk past this particular work of art. He had to acquire that painting; he was 'called' to it.

Gadamer (2014) stated that the work of art is not an object that encounters the human being: "Instead the work of art has its true being in the fact that it becomes an experience that changes the person who experiences it" (p. 107). The experience of being called to something significant is not consciously played out. Gadamer pointed out that play has its own essence, independent of consciousness of those who play. Similarly, being drawn to a work of art and drawn to significant data in transcripts cannot be judged as right or wrong. Being called to particular stories in research data is part of being-there in the experience with the unfolding of the story. Perhaps the story captures a particular mood;

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<sup>1</sup>Midwifery Standards Review is a quality process, part of the recertification requirements for midwives in Aotearoa-New Zealand.

joy, wonder and/or fear. Alternatively, the story may also show the everydayness of providing labour care in a primary unit that is seldom shown and articulated. Either way, it matters.

Verbatim stories were selected to show the phenomenon and ‘lifted with care’ from transcripts to preserve original meaning. Processes used to craft stories are described by Crowther, Ironside, et al. (2016), Smythe et al. (2008) and van Manen (2014). When each transcript was returned to me, I eagerly read the entire transcript. Transcripts were read and re-read to capture possible themes and meaning. Listening to participants’ audio files provided additional information in being-open to intonation and/or concealed insights. I would tentatively copy and paste stories that appeared to reveal phenomena into a new file. Crafting stories involves reducing data; removing extraneous detail unrelated to the story, repetitive phrases, interviewer questions and comments. Further reduction occurred through polishing grammar and ensuring the readability of the story. In this process, I removed identifying features of birthplace, midwives, obstetricians and/or clients. Our spoken language is conversational and differs from writing a succinct story of a lived experience. The process of crafting stories required avid attention to ‘showing’ the enabling, safeguarding and sustaining, in keeping with my question.

### ***Example of Crafting Data***

The following data is from the transcript:

*Often as a call midwife it's really good, both for your relationship with a new, newer midwife, but also... you don't want to put your stamp on anybody as such but I think there's a period of time where you have to all get to know each other and where you may need to step in but also where you need to just be there quietly in the background to offer support without making anybody feel that what they're doing isn't right in a different way.*

From the ‘raw’ data above, the following is an example of crafting the story:

*Often as a core midwife it's really good for your relationship with a newer midwife to offer support without making anybody feel that what they're doing isn't right. There are times where you may need to step in but also times where you need to just be there quietly in the background. You don't want to put your stamp on anybody as such, yet there is a period of time where you have to all get to know each other.*

Crowther, Ironside, et al. (2016) said that crafting “brings the phenomenon into sharper relief in a more concise and readable format” (p. 7). In the process of crafting, the

showing of phenomena is brought to light in a readable way. Interpretations follow to expand on meanings integral to the crafted stories.

### ***Interpreting Data: Circling***

Once data were crafted into a story, I highlighted phrases that revealed the experience. Using the 'show and tell' methods of phenomenological hermeneutics, I 'played' with possible meanings embedded in the story and wrote my interpretations. Interpretations point the reader to what is significant, revealing something that may be hidden in the text. Interpretations are fluid and not rule bound. I moved between the crafted stories, the full transcript, back to the crafted stories. At times I added further data to ensure a story was contextualised. I remained conscious of the pre-understandings influencing my interpretations; for example, I assumed that team support was important in primary units. In listening to stories and analysing meaning, I came to a profound understanding about how much the support of the team matters. Participants referred to one another as 'family' in the primary unit. They described a deep trust formed through knowing each other's practice and relying on one another. During my experience of providing LMC services within the primary unit, I had continued lecturing, thus straddled a number of 'teams'. Working with participants' data, showed that my pre-understanding of valuing teamwork was extremely shallow. I have come to new understandings that my working experiences were on the fringe of the 'team'. Because of the part-time nature of my practice, I was not enmeshed in the team to the extent described by the participants in this study.

Interpreting data within hermeneutic phenomenology becomes all-consuming. As I read the data, I could hear the participants' voices. At times my interpreting meanings flowed easily. At other times, I experienced difficulty finding insights. Smythe and Spence (2012) described the interplay of writing and pondering; there is knowing and doubting; the interpretations are precarious and tentative, always open to the play of further understandings. Smythe et al. (2008) encourage students to 'trust the process' that understandings will emerge from the spiralling processes of reading, thinking, writing, talking, mulling, rewriting. Feedback from my supervisors was valuable in honing my writing toward deeper meaning. Reading philosophy with fellow doctoral students assisted understanding the philosophical underpinnings and meanings in our studies. Paying attention to language and returning to etymological meanings further assisted with surfacing understanding of variable meanings hidden in the texts and guiding openness to new possibilities (Spence, 2016).

After writing interpretations of the stories from each of participant's interviews I compiled files of those showing similar meanings. I re-wrote interpretations to emphasise the uniqueness of each story and the congruence or difference between stories. For deeper analysis, I drew on Heidegger, Gadamer and related literature to achieve descriptions of the life-world. Reading philosophy is a complex process; German words do not translate directly with English understandings and a philosopher's writing can be challenging. Nevertheless, the mood draws one further into interpretations bringing to light meanings in the data. The purpose is to keep questioning, pondering what remains hidden and what might have been missed in coming to an interpretation. Interpreting requires being free to openness and the clearing "where light and shadow play in a way that brings insights and understandings" (Smythe et al., 2008, p. 1393). Uninterrupted immersion in data helps one to come to the clearing where light shines on stories while shadows hint at the 'what if', posing more questions.

Interpreting data led to a process of structuring the myriad of insights from the data into a meaningful argument. In keeping with the research question, it seemed possible to present the data within chapters to directly address and reveal what enables, safeguards and sustains midwives to provide labour care in primary units. Hermeneutic phenomenological interpretation is about eliciting the insights that emerge from each story. In dwelling with the data, I became increasingly aware that multiple intertwining meanings are brought to light through the use of the words enabling, safeguarding and sustaining. The limitations of staying with these three words (and the structure of the three chapters) meant there was a danger of a silo effect, thus losing the integrated meanings. While the three chapters are separate, a considerable amount of data and interpretations could have been presented in any of the three chapters; I made the decision on which of the three aspects were pre-dominant in the story itself. However, this process was not rule-bound and is fluid; there is cross referencing to enabling, safeguarding and sustaining within the three data chapters. There is openness in the interpretations as to what works for midwives providing labour care in primary units. In the final chapter, the inextricably linked nature of these words is addressed; the three chapters become 'the whole' picture of what works for midwives providing labour care in primary units.

## **Trustworthiness of Methods**

Gadamer (2014) described the play of language which draws us into meaningful understandings. He suggested that “The weight of the things we encounter in understanding plays itself out in a linguistic event, a play of words playing around and about what is meant” (p. 505). He further asserted that the meaningful captivates just as the beautiful captivates us; encountering new meaning has something of the truth of play. Morse (2015) challenged the need for explicating rigour in hermeneutic phenomenology where a definitive answer is not sought, but rather where there are multiple ‘truths’. In this study, hermeneutic phenomenology has been conducted in a scholarly manner with attention to rigour.

In keeping with the methods, participants were invited to share lived experience, to offer examples of providing labour care in primary units in an all-encompassing manner. Participants shared their most recent experiences and/or memorable experience of working with women to facilitate labour in a primary unit. Stories vary in length in the data chapters that follow; examples of stories from practice show verification and validity of the researcher listening to the being-in-the-world of participants’ experience.

Validation of methods is shown when analysis is performed on descriptive accounts from transcripts “rooted in primary and scholarly phenomenological literature” (van Manen, 2014, p. 350). In analysing data, I have referred to the writings of Heidegger and Gadamer, alongside scholars who followed philosophers. Meaningful data reveals what is enabling, safeguarding and sustaining, what ‘works’. It reveals and conceals the intricacies of the phenomenon of providing labour care in primary units.

In hermeneutic phenomenology, deeper understandings arise through the meaning in participants’ text, one’s own understandings, understandings of others and notably the play in the circling and spiralling of understandings. How does one know that understandings are meaningful? Spence (2016) suggested that understandings emerge within and across horizons of understandings. The insights within the findings chapter are offered with the expectation they will provoke further contemplation. The researcher is not intent on rules but intent on being faithful to the spirit of Heideggerian and Gadamerian philosophy. As researcher I am open to the journey of undertaking thinking, questioning and writing. There is openness to the playing out of possibilities, further

interpretations and receiving the ‘phenomenological nod’ when presenting findings and having listeners concur with the interpretations. I have presented at the New Zealand College of Midwives Biannual conference, AUT Midwifery & Women’s Health symposium and the AUT Doctorate of Health Science seminars.

Morse (2015) claimed that the duty of the researcher is to remain faithful to methodology and open to further interpretations throughout the phenomenological study. Rigour is achieved with careful attention to methods detailing the process of analysis; I demonstrated the attention given to crafting stories alongside the thinking/writing process to ensure deep analysis (Caelli, Ray, & Mill, 2003; S. J. Tracy, 2010). Sandelowski (2015) suggested the judgement of credible findings depends not only on verifying phenomena. Findings, like good cuisine, need an element of appeal to the taste culture of the reader; the reader needs to enjoy the reading. In my study, journaling, reflecting and engaging in learnings from supervision and presentations, all ensured adherence to the thinking and questioning processes exemplifying hermeneutic phenomenology through the lengthy period of data collection and interrelated analysis.

## **Summary**

The methods used to undertake this study have been described in this chapter. The methods are congruent with the philosophical underpinnings of Heidegger and Gadamer and exemplify hermeneutic phenomenology. The analytical methods entail coming to deeper understandings and meanings of text. There are no claims of generalisation of findings. In the following chapters, enabling, safeguarding and sustaining are revealed through stories and interpreted meanings.



## **Chapter 6: Enabling Midwives to Provide Labour Care**

### **Introduction**

In this chapter, the research question is addressed in relation to what enables midwives to provide intrapartum care in primary maternity units. The notion of confidence emerges as an overarching theme from participants' data. It appears that confidence develops through one's education programme, immersion into community practice, ongoing experience, supportive relationships with colleagues and coaching those with lesser experience. Confidence can be enhanced or diminished, strong or weak and fulfilling or waning. Within the theme of confidence, sub-themes emerge, including: Being drawn into primary unit midwifery, Keeping faith in the 'normal', Dwelling where I want to be, Building and gaining confidence and Using tact in the moment.

Rotenstreich (1972) referred to Aristotle who placed "the brave man [sic] between the two poles of fear and confidence. The man who exceeds in confidence is rash and he who exceeds in fear and falls short in confidence is a coward" (p. 348). One might ask if a midwife is placed between the poles of fear and confidence as she/he provides intrapartum care. Is it possible that the pole of fear prevents some midwives from practising in primary units? It is assumed that some midwives do not wish to practise intrapartum care in primary units and prefer secondary/tertiary hospital settings. Aristotle described the extremes of the spectrum; with rashness in those who might be over confident and perhaps cowardice or timidity in those lacking confidence. How do midwives balance the art of having sufficient confidence to practise away from back-up obstetric assistance, while maintaining enough timidity or fear to not take unnecessary risks? Analysis begins with participants describing how they were drawn in to primary units, pondering what gave them the confidence to make such a step.

### **Being Drawn into Primary Unit Midwifery**

For some participants, their initial experience of a community setting called for a different kind of confidence. Lynn describes her initiation to primary birthing:

*Where I trained was very much the midwives' domain; doctors only ever came into our rooms if they were needed. I moved to community and my first*

*night on call was an absolute baptism of fire. It was my first homebirth witness and then I was called out to my first homebirth myself, so it was an amazing, amazing night. I later worked as a team midwife and you were able to practise as a midwife unhindered, but I think the thing that made it was the midwives all had a very similar philosophy. We had good support, we discussed any concerns and we had a really well organised and run team. We'd drop anything for each other to cover each other and there was a lot of give and take within that relationship and I think that made it for us as midwives. When I first came to this primary unit, it wasn't a thought out decision of 'oh goodness me this is a midwifery led unit'. It didn't fill me with any worry because it felt like going back to that place that has probably given me the most job satisfaction that I have ever had working as a midwife.*  
(Lynn)

Lynn recalls her first night on call, outside of the immediate support of secondary services, as a “baptism of fire”. She learnt by being immersed into witnessing her first home birth (as the supporting ‘second’ midwife) and during the same night, was later called to conduct her first home birth. Managing two home births on one’s very first night on call in the community might be too challenging for some midwives; yet Lynn found the experience “amazing, amazing”. She echoes the old adage of ‘see one, do one’ and embraced this ‘baptism of fire’ as building her confidence in community midwifery. Rotenstreich (1972) noted that within confidence there is an aspect of opinion, such as things will turn out satisfactorily or expectations will be fulfilled. In this instance, both home births went well – probably due to good screening alongside both the woman and midwife having faith in physiological birth. These births reinforced Lynn’s penchant in practising ‘unhindered’ or freely and autonomously, without medical support on site, as a community midwife. For Lynn, coming to work in a primary unit was like going back to her favoured work place and reminiscent of a past that had immense job satisfaction. Past time and present time are intertwined, co-existing and influencing one’s pathway. Stolorow (2014) discussed Heidegger’s temporality inclusive of past, present and future, whereby the ‘now’ is referenced to one’s past and linked with one’s future. Lynn’s past ‘baptism of fire’ reinforces her belief in midwifery led care in the community. Her positive experiences in this setting drew her into primary unit midwifery to work alongside like-minded colleagues and continues to influence her practice and decision making.

Sandra describes her initiation to primary birthing:

*I worked in an area where primary birthing unit or home birth were very much the norm; it was a rural area and they're used to births anyway. The mums didn't want to travel to a secondary unit, and if they didn't need to go in, they didn't want to go in. These women wanted to keep things naturally which was great. So that's where my confidence grew. If you're quite a long way from hospital, transfer is a bit more difficult.*

*I had a first time mum, I checked her over and realised that I had a compound presentation. I said, 'look we do need to go in, this baby is not going to birth with an arm hanging down'. She did need a caesarean because this baby was in such an awkward position but yeah it's those kind of things that you remember and it teaches you to be more self-sufficient. I just worked with these midwives who I admired and I was gaining my experience, gaining confidence, and having them back me up when I wasn't sure. I was picking up the phone and talking to people. (Sandra)*

Sandra says her confidence grew initially through working with rural women who wanted to keep things natural and avoid transfer to the large hospital. She recalls diagnosing a compound presentation (baby's arm presenting in the lower pelvis instead of the head presenting) in the rural setting and this experience reinforced her self-sufficiency rather than leading to fear of birth. Being self-sufficient enables a sense of self belief. Sandra's confidence grew with experience. Rotenstreich (1972) confirmed that confidence is a sense of reliance on one's own judgement, where someone is dependable, trustworthy "because confidence is reliance" (p. 350). Perhaps self-sufficiency and self-reliance are traits necessary to provide labour care in community and/or primary units. In Sandra's narrative, the guidance and back up support from experienced midwives enhanced her sense of growing her self-confidence.

Vivienne echoes the necessity for confidence as a rural LMC midwife:

*I think you've basically got to be quite confident. I think it would be difficult if you weren't confident in your care, especially initially when only three of us were doing LMC work in this area. And you've also got to have collegial support. I think those two things are really important. You've got to be confident in how you work and practise as a midwife and you've got to have that support behind you. You need family support as well. If you haven't got family supporting you and a family that can cope without you from time to time, then that could be very difficult. I don't know how midwives do it with young babies because I wouldn't have been able to cope. My kids were older and I think LMC work would have been really difficult to do when they were younger. (Vivienne)*

Vivienne describes the need for confidence, especially so when only herself and two other midwives were providing LMC services to the rural area. Alongside confidence, Vivienne relates the need for support from colleagues and family. Vivienne states “you’ve got to have that support behind you” in order to uphold, protect, sustain and nourish you to continue in the role. Her family appears to have a dual but potentially conflicting role. On the one hand, her family need to give intense support for her on-call work; yet, on the other hand, the family must cope without her presence and thus support her not being there for them.

In stressing the importance of having confidence, Vivienne suggests it is likely to be difficult for a midwife to conduct the role without confidence. Rotenstreich (1972) described an attitude whereby confidence is a “certain disposition, a manner of behaviour, a posture of habit” that shows itself as an act of conduct (p. 348). The author suggested that confidence has a relation to time and accumulated experience; something happens in that time “until the moment in which confidence emerges” (Rotenstreich, p. 352). This begs the question whether a midwife needs time and experience in order to build the confidence necessary for practising in primary units. Perhaps midwives with confidence are crucial to coach and support midwives with lesser experience and, therefore, less confidence.

### **Keeping Faith in the ‘Normal’**

Further analysis of confidence reveals confidence related to the future. Rotenstreich (1972) described confidence as being deliberately entertained without the person being aware of this deliberate confidence. In turn, confidence can bring disappointment in a similar manner to phenomena of faith or hope; “all of them point to something to come, although the reason for reliance on them is not always stated or clear” (Rotenstreich, p. 349). Midwife participants in this study appear to retain a strong faith in future fulfilment of one’s desire. This faith (interlinked with confidence rather than defining a religious faith) is called upon as faith in supporting and believing in normal labour and birth.

Wanda recalls being drawn to practise within a primary unit from her faith in birth:

*I think my interest in primary units stemmed from my own innate views of birth and we’re actually designed for this. I came from that culture where my family birth well and so it feels like the right place to be in your community where you feel supported and close to home. You hear people say, ‘oh it’s*

*boring out there'. It is never boring out here! In terms of practice, it actually takes a lot of courage, especially if you've worked in a base hospital and you're used to that. And it was part of why I really didn't want to get into that mode (of large hospital practice). I didn't want to lose that innate faith, the faith I got from working here a lot as a student, my own belief in birth, my own experience as a midwife here both as a LMC and as a core. (Wanda)*

Wanda's cultural background influences her faith and belief in primary units as the right place for women to be – labouring and birthing in their community supported by family. She discounts any notion of it being boring in the primary unit. She emphasises the courage required to practise in this setting, particularly so for midwives who have been used to practising in large hospitals with obstetrician and paediatrician assistance on site. Wanda chose to resist getting into the routine or 'mode' of working in a large hospital as she did not want to lose her innate faith and belief in labour and birth in a primary unit.

Robynne concurs with Wanda in keeping faith in normal birth and primary units:

*I did clinical in the primary unit as a student midwife and enjoyed working with the women. My love of primary just built from there really. I saw the benefits of looking after the women in your community and birthing them at the unit. I learned a lot of the midwifery that I use now from very experienced midwives who had lots and lots of experience in secondary and primary units. I am of the opinion that physiological birth will happen, be it at primary or a secondary unit, but preferably primary. I think the belief that birth is physiological, that birth is normal, it is a normal process and it should be treated as normal. (Robynne)*

Robynne attributes her student experience to building a love for working within a primary unit. She is extremely grateful to the experienced midwives who coached her to attain the skills necessary to practise in this setting. She emphasises her belief in birth as a physiological process and, while accepting that normal birth can occur in a secondary unit, she prefers primary units. Robynne's firm belief in 'normal' birth is braided with self-confidence, competence, success (Perry, 2011) and belief in her ability to practise within the context of a primary maternity unit.

Diane has her own belief in 'normal' that fosters her confidence:

*With confidence, I think it goes right back to my teaching and believing in our model of care that birthing is normal until it's proven otherwise. I feel that we're the keepers of normal and if we're going to continue to do that we've got to really work at it, it's my passion. It is like when you see so many normal babies that a baby that's not normal sticks out. It's pretty much the same with birthing. When you do a lot of normal, it's like ooh what's*

*happening here; you start sort of looking and thinking okay, we may need to start changing our plan. And it doesn't happen that often. (Diane 2)*

Diane attributes her teaching or education to cementing her confidence in normal birth. She acknowledges that her experience of seeing many normal births alerts her to recognising abnormal; thus knowing normal helps her see what is not normal. Diane expresses her belief and passion as “keepers of normal” whereby midwives strive in preserving something that is vulnerable and precious. Rotenstreich (1972) described “confidence maintained in its proper limits is conviction” (p. 348). Confidence like hope, is futuristic with desire towards an ideal. Diane has faith and hope in birth being normal “until proven otherwise”. She does not dismiss the abnormal and describes the abnormal as obvious or “sticking out”, meaning that you cannot miss it if you are watching. In such cases, you need to re-assess and possibly start changing the plan.

Faith seems to reinforce Lynn's confidence to practise within a primary unit:

*I think it's about the belief of what is normal and what women can do. It's the belief that it should be normal and it's a life event and it's a physiological thing and yes we know it doesn't fall that way for all women but the majority it does. And we are used to seeing that every day, being with a woman however she needs us, whether it's really full hands on intense support or whether you are just quietly in the background. We see the good outcomes and I think you don't see that in the secondary and tertiary units, and obviously the women are predominantly very different. I also think the women who come here and have their baby, have that intention that they can do this, its normal. (Lynne)*

Lynn speaks of her strong belief that physiological birth is possible for the majority of women. ‘Normal’ is intentional; the women come to the primary unit intending for birth to be normal. It is a state of mind, a belief that is reinforced again and again by births that have good outcomes without intervention. For Lynn and her colleagues, seeing good outcomes everyday affirms their belief in primary units. Lynn claims this does not happen as frequently in secondary and tertiary hospitals; she acknowledges in part that the women are different as they are likely to have risk factors. Alternatively, the women might prefer to labour within a large hospital setting. Vague (2003) offered a salutary message to midwives suggesting that when a midwife has success by supporting one woman to labour without epidural analgesia, this serves to reinforce the midwife's resolve and belief in normal birth. Vague stated, “In the presence of a midwife who is strong in her beliefs about childbirth and strong in her supportive role, it seems that the

woman is able to labour with confidence in the process” (Vague, 2003, p. 90). Both Vague and Lynn reinforce the intertwining of the woman and midwife’s faith in their resolve for normality during labour and birth.

Mary’s personal background influenced her to practise midwifery in a primary unit:

*I went into midwifery from a home birth interest and a strong belief that the reason I wanted to be a midwife was to support women in primary birthing. I believe birth is, or can be, a normal life process for well women. And I want to be part of that. I feel when I’m in primary birthing, I feel more myself. I feel more like I can just be a woman who knows some important stuff who is helping another woman bring her baby into the world. I feel like it’s a strong relationship focus that I’m having with that woman rather than medicalising a process and tubes and beeps and so forth. Birth in hospital can be quite medicalised, whereas in a primary birthing unit it’s much closer to that concept just that it’s a natural physical thing. It’s more about how you emotionally support a woman than the actual tools that you have. I think your hands are kind of the most important, your hands and your voice really! And your eyes obviously. It just feels right for me. I think what gives me the confidence to birth in a primary unit is I still have held on to that belief that birth is safe and is best served, a woman’s chance of having a normal birth is better in a primary birthing unit. (Mary)*

Mary’s background belief in normal birth reinforces her commitment to support women intrapartum in the primary unit. Mary recognises there is a ‘hanging on’ needed to believe in safety of primary unit birthing. She needs to preserve and protect that belief by being immersed in the everydayness of seeing normal birth happen. She feels more herself in a primary unit where she is focusing on the relationship of support with the woman as opposed to the “tubes and beeps” commonplace in large obstetric hospitals. Mary speaks of giving of herself, using her hands, voice and eyes to portray her confidence in birth. Heidegger (1976) described the craft of the hand that we seldom bring to our consciousness; the hand welcomes, the hand reveals one’s thinking through gestures with language or indeed more so in silence. Being herself appears to be a powerful influence in her practice. When is one not oneself? Perhaps it occurs when the dictatorship of ‘They’, the other (Van Manen, 1990) requires the midwife to be practising against one’s own deeply held beliefs; conforming to an inauthenticity of ‘safety’. For Mary “It just feels right for me” practising in a primary unit. Perhaps she is implying that it does not feel quite right to be practising in the more medicalised obstetric hospital.

An obstetrician expresses her experience with primary units early in her career:

*I've done most of my obstetric training in New Zealand, mainly in an area with primary units working as a registrar and a senior registrar. And so I've always been exposed to the LMC model of care and very used to working in that collaborative way. I was exposed to a primary unit quite early on as well so primary birthing unit was just a natural thing to me in the way that you have primary medical centres. And there's more and more research showing that it is safe for low risk women, and I'm very supportive of pro-women's choice, so if that's what the woman wants and she's low risk then, I would support her. Yes, so I guess it's just growing up in the environment and having the evidence to back it up and I guess the knowledge of knowing what are serious risks and what are minor risks. (Sarah)*

Sarah narrates her early exposure to primary units as a natural place for birth and views these units in a similar manner to having primary medical centres. She refers to the research that shows that primary units are safe for low risk women and says there is necessity to differentiate between what is serious risk versus minor risk. Sarah reveals her stance on being “pro women’s choice” hence she supports a woman’s choice to birth in a primary unit providing the woman is low risk. This eludes to a powerful mind-set of taking note of what setting the woman wishes to be in for labour and birth.

Similarly Yvonne, another obstetrician, expresses her confidence in primary units:

*I've never not thought primary units were okay. Well I saw my mother delivering people at home and primary birthing units so why wouldn't it be okay? Most women are supposed to have babies and get pregnant and deliver. I worked in Africa and they seemed to manage very well most of the time. (Yvonne)*

Yvonne’s background and work in Africa instilled a belief that most women are meant to experience childbirth and will manage well, most of the time. Her philosophy of birth is influenced by early childhood years of seeing her mother birth women at home and in primary maternity units. She sums up by saying “Why wouldn’t it be ok” to birth women in primary maternity units; as opposed to thinking most women should birth in secondary/tertiary hospitals.

Obstetrician participants narrate their experience of coming to believe in primary maternity units as a safe place for labour and birth. Multiple notions interrelate and collide in drawing midwives to practise intrapartum care in primary units. Participants describe growing of confidence in order to step into, or stay within, primary maternity units. Confidence is explored within Heidegger’s temporality; one’s belief might emerge from early life experience of seeing normal birth, one’s education programme might



foster the drawing into primary unit care, a ‘baptism of fire’ or that immersion in community practice helps develop a sense of self-reliance in the ‘now’ and for the future. Growth of confidence comprises hope, faith, disposition of self, alongside being supported by colleagues and family. Confidence is regenerated in present and future time by success. Midwife and obstetrician participants acknowledge the power of the woman to choose labour and birth in a primary unit. The woman’s faith and confidence seem to heighten the midwife’s confidence as being the “keeper of normal birth”. There appears to be regeneration of confidence by the interplay of having faith, believing, expecting physiological birth and it playing out in its normality.

### **Dwelling Where I Want to Be**

Dwelling shows how the place of birth, being a primary unit, is felt as lived-space by those who work and dwell in this setting. Heidegger (1993) used ‘wohnen’ to describe growing accustomed to or to feeling at home in a place; yet one must go beyond the security of one’s home and inner space into the world “to fulfil his role in life” (Bollnow, 1961, p. 34). Midwives in this study feel at home within the homeliness space of the primary unit in their community. Midwives experience security in this setting and thus feel able to protect and enable normal birth to flourish. Dwelling in the space of a primary unit enables the midwife to practise in a particular way.

Helenmary recalls being drawn into the dwelling space of a primary unit:

*A position became available at a primary birthing unit and when I went there I thought this is what I want to do, this is where I want to be. I don’t want to work in secondary. I fell in love with primary birthing. The first birth I did in a primary unit was on my third day there. I was the only midwife with two women in labour, so I went from room to room. I was just going backwards and forwards between these women. But I actually found it really empowering, amongst all the sort of newness. But I guess I felt comfortable with birthing and so I wasn’t scared of what I was doing. I had been mentored by a midwife that loved normal birth, I take my hat off to all the midwives that really looked after me.*

*It was just getting to know the place and by midday we’d had two women that had had their babies. I said to the hospital aide, ‘I’d just like you to be here in case we need to do something’ and she said, ‘yeah that’s fine’. And so she came in and we just got on with it and it was fine! It was really lovely just being there with the women. (Helenmary)*

In similar manner to Lynn’s baptism of fire, Helenmary provides care for two women in labour during her orientation to a primary unit. She thrives on this experience and it

confirms this is the space she wants to be. She does not feel scared; on the contrary she expresses delight and describes falling in love with primary unit birthing. Falling in love with practising in a primary unit shows 'relatedness'. Heidegger (1976) suggested that relatedness is what maintains craft; relatedness as occupation responds to human dealings and engages one beyond the "empty busywork" such as dealing with tools or business concerns (Heidegger, 1976, p. 15). While place might commonly be considered the structure of building, field, or perhaps a primary unit; space depicts the feeling of being in that space, the attunement of one to the space they are practising within. Bollnow (1961) portrayed difference in the notion of space by describing the highway or motorway that shoots for destination; the countryside becomes remote as it is passed by. In contrast, there is a different movement and thus a different feeling of space when one loiters on a hiking path. Perhaps the primary unit generates a feeling of space and perception of time that is more akin to the space of the hiking path. Heidegger (1993) revealed the meaning of 'buan' as dwelling in the sense of "an activity... we do not merely dwell - that would be virtual inactivity - we practice a profession, we do business..."...The 'dwelling' is in the manner in which the human or mortal is on earth and in turn means "to cherish and protect, to preserve and care for" (p. 349). In essence the dwelling in the space of the primary maternity unit enables the midwife to practise being-there with the woman and to cherish and protect the process of normal labour and birth.

Diane describes some initial reluctance in being drawn to work in a primary unit:

*The first reason that brought me to a primary unit was where I moved to; it was a long way from home to the tertiary unit. Very scared I was, when I came! I'd only ever done midwifery in a tertiary unit and I was coming to a unit where there were only two staff and you didn't have the back up for emergencies that you had at a tertiary hospital. When I was talking to my colleagues about working in a primary unit, they were like, 'oh, no back up, no one at the end of the phone, no one at the end of the bell' and so I guess that didn't help my coming here.*

*I think experience of doing primary unit midwifery and learning that 75% of pregnancies are fine. And of the 25% that are not and need tertiary care, a lot of those women are sifted through before they even come into labour. It was fine. It took me a little while to adjust to the smallness of the unit. I was mentored extremely well and got orientated well to the unit. I think night duty was daunting because there's fewer staff compared to daytime. I guess it just becomes time and experience of working in a unit and gaining confidence of your own abilities and making the calls. (Diane 1)*

For Diane, working in a primary unit is convenient because the tertiary hospital is a long way from her new residence. She had vivid memories of being scared of midwifery practice within the primary unit and colleagues in the tertiary setting exacerbated her fear by emphasising there would be no one at the end of the bell, no immediate on-site emergency backup. Diane recalls how her fear was resolved through experience of working in a primary unit and learning that “75% of women are fine” and those women who need tertiary care are often “sifted through” or screened out of primary unit care prior to labour commencing. Perhaps there is a myth that unexpected emergencies are common within primary maternity units, when in fact these situations occur infrequently due to the sifting, sorting, and screening of women. Diane’s experience suggests that midwives who have worked in tertiary hospitals still need mentoring and support to grow their confidence at a primary unit. This confidence and self-belief is essential to make “the calls”, to make decisions necessary for safety within primary maternity units. The decisions that midwives make during labour in a primary unit need to be autonomous and confident. The nature of primary units is that of fewer midwives on site and this might be daunting, particularly during the night hours alongside the remoteness of a primary unit.

In Kirstin’s case, she was already drawn into the primary unit and moved residence to be within proximity:

*I actually moved out here to work in a primary unit. When I was a student I did a placement in primary. So when I came out here and worked with the LMCs out here, it pretty much settled me for wanting to work like this. I enjoy being able to kind of make women work for themselves and keep it as normal as possible for as long as possible really. I enjoy women being able to have babies naturally and normally. My experience with large hospital has never been the case of normal. I personally don’t feel whenever I walk in those doors that I have that flexibility to work as primary as I do here. I feel like you’ve always got people trying to watch over your shoulder and you’ve got a lot more clinical pressure on you from people watching and putting their expectations on how you should practise, as soon as you walk into those secondary facilities. I’ve always felt it and I think the busyness of it just doesn’t allow you to have good support so then you manage things a lot differently than you do in a primary unit. I feel like I can turn around and call anyone into a room in primary. In the secondary services, I don’t feel the same. Like in a secondary facility, even if I’m still practising primary, I don’t feel as safe in there. (Kirstin)*

Kirstin moved residence to work in the primary unit that she had been introduced to as a student midwife. She thrives on working with women to keep things normal in this space.

Kirstin, experiences a lack of flexibility in the space of the large hospital, a feeling of being watched over her shoulder by ‘them’. She senses different expectations, in part due to the busyness of the hospital and does not believe that she can practise in a primary manner in that space. On the other hand, Kirstin knows and trusts her colleagues in the primary unit; this trust means she is completely confident to call upon any one of them giving her a feeling of safeness. Bollnow (1961) related the space from one’s home that is known and constitutes a protective neighbourhood with trusted relationships and friendships. The primary maternity unit can be considered as being within the known space of the neighbourhood when compared with the ‘comparatively or completely unknown’ space of the large hospital. Kirstin and her colleagues perceive the primary unit as homely. Trust flourishes when lived space fosters a spirit of collegial relationships. Flores and Solomon (1998) stated that Aristotle assumed trustworthiness is a virtue of ‘good’ people, while trusting is more complex and requires successful relationships. Kirstin and colleagues have forged successful relationships that translate into them functioning well together, trusting one another in their everydayness in the primary unit.

### **Building and Maintaining Confidence**

Building confidence in others is a manner of teaching. Heidegger (1976) stated that teaching is more challenging than learning and calls for the teacher to withdraw and learn to let them learn. The relation between teacher and learner needs to be genuine, not contained in authority but rather etched in both teacher and learner learning ‘thinking’. There is a holding back of the teacher to enable the learner to learn a new skill. The teacher’s comportment entails an emotional dwelling that develops learning through authentic care (Stolorow, 2014).

Helenmary discusses working with a new graduate midwife:

*I think that the more senior midwives have to provide support to new grads. I like them to do hands on. I tell them I’m in the background and just recently, I said to this new midwife who I knew had not had a good experience, ‘Now I want you to look after this woman, I’m here’. I didn’t necessarily go into the room actually. I said, ‘I’m here, I want you to do this because you’re very capable of doing this but I’m here’. And if I’d had to go in to the room I would have gone in. (Helenmary)*

The newer midwives need to do ‘hands on’ intrapartum care and Helenmary encourages this by being-there in the background. She is boosting confidence by saying “you are capable, you can do this and I am here” if needed. Helenmary is ‘leaping ahead’ and in doing so, she is acknowledging and affirming the new midwife in an authentic manner. Heidegger (1996) described *Fürsorge* as a mode of care encountering the other, acknowledging their being-in-the-world; leaping ahead as authentic care entails anticipatory thinking, concern and nurturing that lets the other ‘be’. Helenmary frees the new midwife to practise labour care and to develop ‘selfhood’ (Stolorow, 2014) and thus develop one’s confidence. Rotenstreich (1972) stated confidence is the opposite or contradictory to fear and when “maintained in its proper limits is conviction” (p. 348). A midwife needs conviction in order to foster trust and believe that outcomes will be satisfactory.

Mary speaks of the fluctuating nature of her confidence:

*I had an incident where I nearly did lose my confidence in that I had a woman who I took over late in the pregnancy, she was 37 weeks. The baby’s growth had slowed but she had declined the induction, anyway she’d gone into labour spontaneously. She birthed beautifully. And then just as she lay back, to enjoy her baby, she started bleeding. Long story short, she had this really traumatic post birth experience where she had a large PPH and I felt quite out of my comfort zone. You ring the emergency bell and they all come in like locusts. I was standing there delivering the placenta and the obstetrician physically moved me out of the way ... But anyway there was blood for Africa, they were off to theatre, she lost a phenomenal amount of blood, I think 3 litres or something.*

*But what was interesting about that experience, because I just thought to myself, ‘oh my goodness, what if that happened at the primary unit’? And the obstetrician came back and found me afterwards, because I stayed on to be with the partner and the baby. The obstetrician said, ‘now I want you to know that nothing you did there was wrong. Everything you did was absolutely fine’. And I thanked the obstetrician for telling me that and I said, ‘what will happen if this happens to me in a primary birthing unit’? The obstetrician said, ‘nothing would have happened. All you would have done is got a couple of lines in, you would have followed the transfer and we would have just dealt with it here and it would have been fine’. And that was really good for me. A senior midwife who was aware of the case said the same thing to me. She said, ‘you must not take that on board’. I think that was the occasion where I did waver and I thought, ‘oh my goodness what on earth would I do’? And so I had to be quite stern with myself and park that in a little compartment and keep repeating in my mind okay, so when I went to a primary unit, I really made sure that I know where the emergency gear is. I really make sure I’m familiar with the transfer arrangements. And it’s kind of like your armour or your little protective strategy is in place and then I can kind of park that, and then come back to just being with women.*

*I don't actually do anything in particular, anything different, but that got me through. Like I make sure that the woman is normal, everything is normal as you would with your little checklist. You know baby's heart rate is fine and the woman's observations are all fine and all of those things are in place. And, now I think enough time has elapsed that got me through the hump where I lost confidence. I was shaky and now ...I think philosophically I am just a primary birthing person. (Mary)*

Confidence fluctuates. It can be gained or lost, strengthened or diminished. Mary was the LMC amidst an unexpected postpartum haemorrhage occurring at a secondary/tertiary hospital. After the event, an action plan was discussed should a similar event occur in the primary unit. This dialogue restores her confidence in managing emergencies away from the secondary/tertiary hospital. Mary remains mindful of possibilities, she checks the equipment over and over. Preparing for emergencies is akin to strengthening her armour; this is a shield of defence to protect her during any emergency. She says she has moved from losing confidence, being 'shaky', to being philosophically content with practising in a primary unit. Rotenstreich (1972) conceded that exposure of confidence can lead to the phenomena of disappointment; however, confidence is also anticipation that relates to the future. Mary's anticipation leads her to being prepared for emergencies and transfers. This preparedness augments her confidence. The astuteness shown by the obstetrician and senior midwife in debriefing helped in restoring Mary's confidence. Confidence, as attitude, contradicts despair and, as Mary reveals, one steels oneself for positive future events.

Each participant is drawn to the dwelling space of a primary unit. The spirit of safe practice (Smythe, 2003) in a primary maternity unit is captured in the nuance of confidence whereby the practitioner knows the right thing to do. A midwife working in the primary maternity unit will frequently be the most experienced practitioner on site, and some distance from obstetrician support. The midwife needs a sense of self-belief in order to make decisions for safe practice. The experienced midwife might leap ahead to teach a new midwife while remaining as the backstop should she be needed. Building confidence in others appears to sustain one's own confidence. When a space is created wherein normal birth is protected, women and midwives start with a belief that the birth will be normal until proven otherwise. Midwives who practise out of their own selfhood do so with a particular kind of confidence. It is a confidence that moves beyond the techne of practice to reveal practice wisdom known as phronesis. Phronesis requires practical judgements and is the ability be attuned to the experience of being-there in each practice

encounter (Smythe, MacCulloch, & Charmley, 2009). Phronesis entails trust without a method or step by step process. Phronesis incorporates the notion of tact, the moment by moment knowing. The following stories showcase practice-in-action where midwives are enabled to practise at their best, drawing on practice wisdom and responding to the moment of 'now'.

### **Using Tact and Being in the Moment**

The notion of tact describes a knowing that is intertwined with confidence. Smythe, Payne, Wilson, Paddy and Heard (2014) referred to tact within postnatal care as being a silent knowledge and knowledge without theoretical base. Tact cannot be reduced to a series of techniques or skills. van Manen (1995) spoke of teachers who must “constantly and immediately act with a certain degree of confidence” (p. 42); where confidence is applying knowledge in practice. Similarly, midwives must respond in the moment without time to perform a rehearsed response to any given situation. van Manen referred to tact as a certain kind of acting driven by thoughtful human interaction, in contrast to a thoughtless or pre-determined scripted response. The following midwives reveal their unique personal style in displaying the notion of being with tact.

Sandra talks about a birth where she was pleased with the outcome and proud of the family:

*I had a lovely young woman, first baby, who I'd birthed her sister and cousin. She thought yes she would have this baby in primary and she wanted to use water which was great. It was a Sunday afternoon, her labour was quite short but in transition it was getting a bit longer. She was starting to say, 'I think I need to go to hospital, I think I need an epidural'. The family were really supportive; we had the sisters and mum there. Dad was supposed to be away but stayed to watch his grandchild being born. Just as she was saying I think I need an epidural, I need to be out of here, he started singing. The family worked as a group and they all started singing and that just gave her that little bit of extra boost and confidence. Some of the songs were Māori. Her partner got into the pool and supported her through that last little transition. About an hour and a half afterwards we had a baby in the water and that birth was amazing, it really was; she was absolutely wonderful.*

*That is a memory I think I'll take with me a long time. I knew she could do it. The baby was absolutely fine, the heartbeat was fine. It was her lack of confidence, her thinking I need to get out, I need an epidural. But it was how the family worked together and that confidence came back and it just helped her shift from transition to pushing that baby out; it's the power of family. I think it was the family trusting me, which probably made a bit of a difference. I'd birthed her sister and I'd birthed the cousins and they were all there and*

*they had the confidence that I would tell them if they needed to move or not. And that's what kept them going that we can birth here, we'll be fine. It was really amazing and she taught me a lot that day I think. (Sandra)*

Several things are in play during the crucial latter stage of this young woman's labour. Sandra credits the family for getting this woman through transition in the primary unit; yet it is midwife Sandra who is being patient. She supports the partner to join the young woman in the pool and she embraces the energy in the waiata (songs) by the whānau (family). The family trust Sandra and have confidence in her. They know she practises safely and would make the call if transfer was necessary. Sandra demonstrates sensitivity to this young woman and to the whānau supporting her. Acting in the moment without pre-arranged time to consider the situation and deliberate is how van Manen (1995) described the notion of tact intertwined with confidence:

This confidence is already a kind of situated practical knowledge that inheres in the act of tact itself there is not time for the person to deliberate (rationally, morally, or critically) what he or she should do or say next. (van Manen, p. 15).

Tact necessitates a special sensitivity to situations and how to behave in them; principles of knowledge alone are inadequate (van Manen, 1995). Sandra's use of 'tact' encourages the whānau singing, she supports the partner entering the pool to intensify support. Sandra acts in the moment, in a 'tactful' manner appropriate for the social context of this situation. Amidst all of this happening, the family are trusting of Sandra that she will intervene if things are not safe.

Diane describes a situation with particular challenges:

*This woman started labour at home and she had a history of abuse so we had negotiated not doing vaginal examinations unless a need. I thought she was in transition but she said, 'I can't do this, I need a caesarean'. So I said, 'right, what we'll do is transfer to primary. I'm going to get you on that gas and then we will need to do a VE, I need to know where you are at'. It was a long labour, I had been with her the night before, and then gone back the next night. She was frightened about having the examination, but I needed to know that for my own safety and for her own safety because I didn't know whether she was 2 centimetres or about to birth. She kept saying I can't do this and dah, dah, dah, and getting quite aggressive and really hard to work with. It was the right thing to move. This was a situation that she could have had a long way to go and if that was the case, we would have had to manage it at the large hospital, she was past primary.*

*She actually changed by the time we got to the primary unit and I didn't even do the VE because there was obvious signs. She was really happy after the*



*birth, she went home in a couple of hours and there was no 'oh I wished we'd stayed home'; she realised that she had hit the wall. It is really sad, because it's amazing our brain and our body; if it is working together, it can work really, really well but if you're getting mixed messages it can really stuff it up. I was exhausted after this. (Diane 2)*

Diane shows tact; her thoughtful action is to transfer this woman with a history of abuse from home to the primary unit, rather than a large secondary/tertiary hospital. The client needs privacy. Diane believes this more likely to be provided in the primary unit. She has been with the woman for a long period, the woman is exhausted. Just as they arrive at the primary unit, things change and birth is imminent. Heyd (1995) suggested that tact is distinctly different from morals or manners; tact deals with matters in a way that is not rule-bound but by sensitive perception. It is centred on the welfare of the other. The motive for displaying tact is that of considerateness for the other person. Similarly, van Manen (1995) stated that tact manifests as thoughtfulness in interactions receptive to the social context. In this narrative, Diane's actions are influenced by the social, cultural and ethical notions of keeping this woman's space safe. Tact can also be viewed as moral concern; Diane is tactful for the sake and good of the other. Diane's action is influenced by her knowing this woman's history of abuse. She displays moral concern for the woman and respect for her privacy. Diane describes her constant thinking, negotiating and planning with the client to achieve the best outcome in a holistic manner.

Mary describes a situation where time is ticking by and she is concerned this woman having her second baby is taking too long:

*This woman was remarkably controlled, she was 8 centimetres before she got into the pool and I figured she was really acting like she was fully. Then the contractions had gone off a bit and she wanted out of the pool. When she got out, I could see that rhombus of mikalus and again no urge to push, but not all women get that expulsive feeling of wanting to push. I was kind of looking at the time thinking oh it's ticking on, fetal heart rate is fine and everything. I did a VE, absolutely fully, nothing in the way and still no baby. I encouraged her, talked about how it can feel stingy and you've got to push past that and still nothing.*

*I found a picture of LOA (left occiput anterior), the perfect presentation and I showed her this diagram; I said, 'Look, this is what I feel when I see your baby, baby's just sitting there'. Anyway, she got up off the bed, her waters broke, and then she was quite expulsive all of it, and she just went from zero to hero. So I sat on the floor and she got on her hands and knees. I got the husband to ring the bell because I could see the vertex and I realised I'd been so intent on just being with her, I hadn't even opened a birth pack, so in terms of getting ducks in a row, these ducks are all over the place.*

*By the time the core midwife arrived in the room I could just see this baby's going to turtle<sup>2</sup>, and I just said to the woman, 'Just pull yourself up a bit' and she did and then she said she felt baby had clicked around. She could feel her baby rotate around and birthed and I just passed the baby through her legs, in front of her. I really believe with that woman it was just this control, control, control and then it was almost like giving her, I don't know, not giving her permission, but I guess letting her know that everything was safe for her to leave that stage that she had managed and controlled and go into the scarier phase. That was her second baby and she had a lovely birth. (Mary)*

Mary describes a woman who should birth quickly and well with her second baby. As time ticks by, she confirms full dilatation and that there is nothing impeding birth of baby. Mary shares a picture with the woman assuring her that baby is in the perfect position. This assurance appears to change the woman's demeanour. The woman becomes actively engaged toward birthing her baby. Meanwhile Mary has been totally pre-occupied with the stalling of second stage, hence she forgets to open and prepare the birth pack. She describes the "ducks [being] all over the place". Smythe (2003) illuminated the spirit of safe practice as an attunement, a mindfulness, a way of being with. Mary's 'being with' this woman led her to showing the woman a picture to release the stranglehold of stalling during second stage. Thus tact is exercised within the realm of mindfulness and attunement to safe practice.

Helenmary relates a situation where transfer to the large hospital is being considered:

*I was looking after a young Māori woman, she had her mum and sister as support and she got to fully dilated and then she just couldn't do this. She's a primip and she wasn't doing this, she wasn't pushing, she wasn't doing anything and I'm thinking oh! So I sat down and I said to her, 'yes it's really sore and really painful but actually, it's going to take us half an hour to get an ambulance here for a transfer. When you get to the hospital, the doctor has to see you, they've got to get an epidural in and that's another half hour at least'. So I said, 'that's an hour. Then they'll leave you for half an hour or something to let everything work and the baby to come down. Or, we could just get you in a position that's okay and we can just try some pushing here. Her mum was standing there looking at me and looking at her and she said to the daughter, 'Well that does it, you're actually going to push this baby out, come on let's get organised here'. And she had the most beautiful birth, she felt so empowered, and that's what makes me be a midwife. Sometimes you need to give women the facts. I probably do that now whereas as a young midwife I would have gone to the phone and said this woman needs to*

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<sup>2</sup> 'to turtle' meaning that the baby's head (lower face and chin) is retracted back into the perineum due to the shoulder not rotating – a warning sign for shoulder dystocia.

*transfer now, I've tried everything. Whereas I'm kind of a little blunter now with women, because you feel confident in what you're doing. I knew that she could birth here, if she could get her head in the right space to do that.* (Helenmary)

Helenmary is using her experience and tact to assist this young woman to birth in the primary unit. She reflects that in the past she would have picked up the phone to instigate a transfer acknowledging that she had tried everything. Instead of undertaking a transfer, Helenmary confidently explains the temporal nature of transferring to the large hospital; the need to be assessed, the need to wait for an epidural and then to wait for baby's descent once the epidural is functioning. She offers an alternative proposition to the young woman suggesting some pushing in the primary unit to assist descent and birth of baby. After this dialogue, the young woman's mother seizes the moment saying, "Let's get organised here". Helenmary admits to being forthright in giving women the facts. Yet what Helenmary describes as bluntness, might resonate with the notion of using tact whereby she responds in a fitting and appropriate manner to a particular situation (Heyd, 1995).

Diane recalls a client who surprisingly chose to birth in a primary unit:

*This woman had a history of rapid birth, feeling of loss of control and a third degree tear from her first child at secondary hospital. Her fear of birth was extreme, abnormally extreme. Her pattern thereafter was to have an induction of labour at term and early epidural. When she booked with me, I was expecting the same plan, but she said, 'No, I want to birth at primary' and I just about fell off the chair! I don't know what made her think that, but that's what she wanted. I had her reviewed by the consultant because of her third degree tear, and she was cleared for birthing in primary.*

*I was a bit nervous about looking after her and I had said we will make a very clear birth plan. I explained that I would get help when it came to transition and pushing and I would focus on her. And that's exactly how it went. She came into the unit and quickly went into advanced labour and then birthed in the hands and knees position; a lovely normal birth. I managed to focus on her and talk her through it, so that she didn't as she said, 'lose the plot'. And the midwife who came in was spectacularly supportive. It went so well that postnatally she said, 'I just wish I was going to have another baby'. It was like that birth had wiped out all those terrible experiences. It was actually amazing. She gave me the most wonderful feedback for midwifery review.* (Diane 1)

Diane speaks of a woman who previously 'managed' trauma from her first birth by planned induction and epidural. With this pregnancy, the woman informs Diane of her

wish to birth in the primary unit. Diane's surprise is profound and she admits nervousness in planning care for this client. She displays tact by ensuring she can be completely focussed on this woman during labour and birth; she enlists the help of her colleague in the primary unit to enable this. The woman is delighted with her birth, to the extent that she wishes she could repeat the experience. It appears to heal the past. As van Manen (1995) noted, there is no script for managing human science, it is managed with the notion of tact and the person being confident to find the right way to act in each individual situation. In this instance, Diane acts in the right way and enables this woman to have a positive experience of birth that appears to relieve previous negative experiences.

Lynn recalls a situation of a client with definitive expectations:

*This woman was 42, having a second baby after 18 years, so it was a little bit of a surprise for her. The first birth had been complicated with pre-eclampsia and a lot of choices and plans had been taken away from her as she was very unwell. When she came in, she was extremely direct with me about I want this and that, I want to make my choices. She was so on edge that she sounded quite abrupt but once I said, 'Right you're in control, you tell me what you want to do and I'll just support you and I'll talk to you if I need to inform you of anything,' the atmosphere did change, you could see she became more comfortable. She got in the pool and that really did change her whole demeanour. She lost that focus around having to be in control and got in to the birthing mode I would say.*

*Luckily I had witnessed one water birth and so the water didn't faze me because even though I hadn't done any I knew the research and the care so that was okay. I did talk to the other midwife in the unit and say I've never done a water birth and she said, 'that's fine, you do it and I'll talk you through it'. In my head I was quite nervous but she was actually progressing so beautifully and it was lovely. The midwife and I did the birth in a conversational way around the woman. I would say it would have sounded friendly, it was guiding to me but it would have sounded, without any concern within the conversation that we had around the birth. (Lynn)*

Lynn cares for a woman who is extremely direct and intent on pursuing options not possible 18 years previously when her pregnancy was complicated by preeclampsia. Lynn assures the woman she is in control and reiterates the importance of her expressing her wishes (despite the client being vociferous about these). Lynn puts aside her own anxiety and facilitates the use of the pool with guidance from a supportive midwife colleague. Heyd (1995) furthered his analysis of tact as sometimes being the 'smoothing' of relationships to assist good will. There is an immediacy in the notion of tact whereby one displays empathy for the other in that moment. Lynn de-escalates the abruptness of the woman by reassuring, calming, listening and asking her to express what she wants.

Lynn does the right thing by involving a colleague to guide her during the water birth whilst maintaining a sense of confidence and tact in managing this client in this context. Tact has been linked with special sensitivity at any given time that is unrehearsed and Gadamer (2014) noted paradoxically that saying something tactfully might mean one passes over something:

But to pass over something does not mean to avert one's gaze from it, but to keep an eye on it in such a way that rather than knock into it, one slips by it.... It avoids the offensive, the intrusive, the violation of the intimate sphere of the person. (p. 15).

Lynn exemplifies tact in avoiding a conversation about the woman's approach and demands. Instead, she attunes with the woman, asks her to tell her more and insists the woman has control.

Wanda shares a story of trust and use of tact during a challenging situation:

*This woman was exceedingly vocal! And it was a stressful situation. At the height of each contraction her mouth opened wide, beautiful elegant woman. And she was saying "f..., f..." I can see her uvula shaking. I came in with a really fresh approach as the LMC needed support, she was thinking of transfer with her distress. It was really up there in terms of reactions, you know people can go inside themselves and people that come out, and she was, very much one of those latter.*

*And I think we put a luer in, she was on the birthing ball and did a few things getting ready for transfer, but slowly. She had progressed really well in spite of her distress. It was almost like, that bit of sharing with the LMC, together we stayed to share the distress of the woman and she birthed, actually birthed here. We closed the doors so that her screaming didn't go out quite so much and that support was absolutely crucial to her birthing here.*

*It was distressing. That was one of the most distressing and challenging births I remember! The LMC told me later how grateful she was for the support because the woman and her partner had both said that they wanted to go to the large hospital. She said it was my freshness coming in, doing the steps to start the process of her going but also going slowly. Because you could see... Sometimes there's a, let's ring the ambulance. It's like that leap of faith that you know, probably... We should know more than what the woman knows, what's likely to happen, because she hasn't been in that place before so she's, clearly distressed. You know that either the progress is happening or yeah. And that was, she had a lovely birth here. Once she was pushing she took control. She was amazing. She pushed quite quickly too. You got a great sense of confidence in her ability to birth from what you see and know. I talked to the LMC about this birth. Even though she was an experienced midwife she said I had given her confidence, reassured her, calmed her down. Together we got this woman through! (Wanda)*

Wanda describes a woman who was exceedingly vocal about her pain and the LMC midwife was thinking transfer was indicated. Wanda describes assisting the LMC with the process pre-transfer to the secondary/tertiary hospital, but does this process “slowly”. She stays with the LMC to share the distress and give continuing support. Wanda recalls this occasion as “up there” among her memories of distressing and challenging births. She remembers the “leap of faith” wherein her leaping ahead provided confidence and calmed the situation. Acting ‘slowly’ when undertaking the tasks prior to transfer is a ploy associated with giving time to enable the woman to progress and have a normal birth in the primary unit. Wanda says that as midwives we should know more than the woman and act on this knowing with a sense of reassurance. The woman pushed well in second stage and birthed successfully in the primary unit. Acting with tact demonstrates perceptiveness, understanding, and insight where the right actions are not a patterned process of sequential steps. Wanda’s perceptiveness and acting ‘slowly’ shows tact in action. She says they did precautionary tasks such as inserting a luer in view of potential transfer yet she had the confidence that this woman would birth her baby in the primary unit and this was vindicated.

## **Conclusion**

Enabling is first of all having the confidence to step into primary unit practice. Enabling is about growing confidence in self and growing confidence in others. Keeping faith in normal enables a practice that upholds the normal, while all the time being alert to what is no longer normal. The place itself becomes a space that protects and enables normal labour and birth to flourish. Something ‘happens’ through seeing good outcomes whereby one’s faith and hope in normal are reignited. Participants revealed the use of tact in the moment, to make decisions. Enabling intrapartum care in primary units encompasses being “keepers of normal” yet, in this keeping is a sense of watching out for the abnormal and acting accordingly. In the following chapter, safeguarding is analysed by drawing on data that relates to preserving and protecting.

## Chapter Seven: Safeguarding Labour Care in Primary Units

In keeping with the research question, this chapter follows on from what enables labour care in primary units and introduces themes associated with how midwives are both safeguarded and safeguard themselves to provide intrapartum care. Safeguarding is vital to ensuring mother and baby come to no harm. In other words, what safeguards midwives in turn safeguards birth. Participants were invited to share an experience of a challenging situation while working with a woman in labour at a primary unit. Narratives that show safeguarding are analysed to reveal meaning; notions from Heidegger and Gadamer are used to deepen understanding.

The skills and experiences of individuals are central to safeguarding. Midwife managers in this study emphasise their responsibility and iterate feeling responsible for everything that happens in the primary unit. As stated in chapter one, stand-alone primary units are distant from a secondary or tertiary obstetric hospital which has ready-access to doctors during emergencies. In primary units, midwives must manage events always mindful of this distance. There are fewer people on site, one or two midwives, or perhaps a midwife and health assistant who need to work collaboratively, stepping up to meet the next challenge. The notions of space, distance and confidence in one's self (explored in previous data chapter) are intertwined with safeguarding labour and birth in primary units. Safeguarding is described through notions of: Beginning with self, Safeguarding with others, Expecting the unexpected, Working with the whole team, Recognising normal and not normal, Making the call, Leaping ahead to safeguard, Being thrown into situations and Safeguarding through the dread.

### Beginning with Self

Safeguarding begins with 'self'. There are things the midwife can do to sustain and enhance the safety of her practice. Robynne speaks of being prepared:

*Myself and two other midwives went off and did the ALSO (emergency) course a few years ago and found that really invaluable. That was a great course and it was hard work; it was a weekend of intense education but everybody that I know that's done that course, has really thoroughly enjoyed it and learned some good skills out of it. I always worry about the junior staff in terms of the new grads or the people on orientation because they're still new and I don't know whether I would have been able to manage an undiagnosed breech if I was new, I don't know. Because I'd just done my very*

*first one and I sort of thought oh my gosh! This baby's not coming the right way, and yes you've done all the learning about it and you know the mechanisms of it but when you're faced with that lady and knowing that it's a 20 minute transfer. And you think if she's not fully dilated and we've already got legs out, what do we do next? I don't know if as a junior midwife I would have actually coped as well as what I did as a senior midwife – does that make sense? (Robynne)*

Robynne describes acquiring emergency skills that proved valuable when faced with a situation of an undiagnosed breech in the primary unit, miles from the secondary/tertiary hospital. Sometimes theory alone cannot prepare the midwife adequately. In this case, the woman presents in labour with the baby's legs hanging down from her perineum. Robynne knows that transfer will be too slow to ensure the survival of this baby.

In this unexpected emergency, Robynne undertakes an assisted breech birth. Despite the dilemma, her response demonstrates a pathway of sound reasoned judgement (Shotter & Tsoukas, 2014). Smythe and Norton (2011) noted that someone needs to willingly take the lead enacting the wisdom of practice. Her rehearsal of emergencies along with being a 'senior' midwife enables her to manage this situation successfully. There is a blending of previous learning (both theoretical and experiential) wherein the latter cements the former. Preparation, such as completing an emergency course and watching numerous breech birth adds to the background of experiences she has already embodied. In the moment safe practice comes, the midwife's readiness safeguards.

### **Safeguarding with Others**

The self is always with others and relationships are grown through midwives working with others. Sandra describes herself and others preparing for emergencies:

*We have a PROMPT study day that is actually in the primary unit and I try and attend that day rather than the large hospital course because I think it's more important to go with the team that you're most likely to be working with. Most people can deal with an emergency in the large hospital; you've got that many extra people around you! But when you're in a small unit, it actually pays to work with the people that you are more likely to have the emergency with because you then get to know different personalities and who can do what, and who's better at organising and things like that. So that's why I quite like doing the PROMPT days in the unit. I think I'm possibly the one that says okay we need to do this, we need to do that; I tend to be the vocal person, unless I walk into the situation where somebody's already doing that well, and in those cases, I say, 'what can I do to help, where do you want me? What do you want me to do?' You already know the personalities of those midwives working there, you know their strengths and*



*what they are best at through working with them and seconding at a birth with them. (Sandra)*

Sandra reinforces the value of practising emergency skills with the team in the primary unit. She displays a knowing and trust in her colleagues; she is aware of personalities and who takes various roles. Heidegger referred to dwelling where surroundings have an effect on being and being has an effect on surroundings (Gelven, 1970). Sandra feels confident in the dwelling space of the primary unit; her knowledge is heightened by training for emergencies in this context. Sandra's knowledge and concern provide guidance for safeguarding practice during emergencies in primary maternity units such as:

- Getting to know the personalities, who is best skilled at what, who is best at organising
- Ensuring someone takes the lead and is vocal saying 'we need to do this and that'
- Asking clearly what one can do to help when someone has taken the lead
- Learning about other midwives' practice by seconding at their births, working alongside them

Emergency updates are primarily about refreshing skills. Sandra extends this to recognise how important it is to know the people one will depend on for support. In a large secondary/tertiary setting one works with a wide range of people. Perhaps protocols safeguard the process. It seems in this primary unit there is almost a choreography, a rehearsal, an opportunity for the players to 'get it right' before the emergency comes. The next emergency situation is safeguarded by midwives who have spent time together practising what to do and how to work together.

Similarly, Kirstin and Diane emphasise the value of emergency skills specific to primary unit midwives:

*I do the PROMPT study days every year, the last couple have been here so they have done them quite specifically directed at us. I enjoy them; I like skill based stuff and learn a lot better with hands on. I tactilely like to be able to do stuff. (Kirstin)*

*It's just keeping your woman safe and also keeping yourself safe professionally, so you're keeping up to date with all your things. And things like PROMPT they tend to focus more on a primary unit so that's helpful instead of having a midwifery study day that only talks about birthing at a tertiary unit. So it helps to have those primary unit study days that focus on what you do out here about things. But I guess it's just having done some*

*tertiary and having some experience in abnormal I think makes a difference. That's a personal opinion. (Diane)*

Emergency updates specific to the context of primary units are valued. Kirstin attends on an annual basis and emphasises that tactile learning works for her. Diane speaks of the PROMPT emergency course focusing on 'out here' the space that is distant from tertiary hospital. This course assists her to keep women safe, which in turn keeps herself safe professionally. Diane believes past experiences of seeing abnormal births helps her to manage emergencies. Again, there is a coming together of previous experience, learning from courses to bolster safe practice and being ready for 'anything'.

### **Expecting the Unexpected**

Midwives can be faced with the unexpected in primary maternity units. Robynne describes needing to be ready for any possible situation:

*When I talk to the new staff, I always do talk to them about the possibility of having an undiagnosed breech here because we do get them. It's not a one off, they happen. And so I say to new staff to expect the unexpected, and that yes we are a low risk primary unit, but you may actually get a very complicated person walk through the door. Yes we're supposed to be primary and we're only supposed to do low risk births but there are the women that come in; the slightly bigger BMI (body mass index), the slightly lower Hb (haemoglobin), the undiagnosed breech, previous retained placenta or a previous blood transfusion. These women will sometimes rock up here because it's the safest place for them to be.*

*Then we have the odd one that wants a VBAC (vaginal birth after caesarean) at home and the LMC has said actually, 'No, that's not safe'. I don't know whether the LMC says just wait at home, who knows, but they do seem to arrive here and they are pushing. I am of the belief that if the baby is coming and coming fast, it's going to be okay. Whether that's just me trying to keep normal I don't know. All of the babies that have been born on the front deck or in the car park or at home and transferred in, they haven't been a problem. One or two of the women had a bleed once they got here and delivered. (Robynne)*

Expecting the unexpected is part of being-in-the-world in primary units where 'thrownnness' is "thrownnness-with and for other; the world has to be taken care of with and for the other" (King, 1964, p. 109). Dealing with the unexpected necessitates self-reliance. Robynne cautions the listener that a low risk unit is no guarantee that women presenting will be low-risk. In fact, the women might have significant complications. It is not enough to be prepared for normal birth; one must be prepared for any possible

scenario. The midwife safeguards herself with a sense of trust that she has the skills to cope with whatever arrives at her door; she proves that to herself in each situation that arises.

Being ready for anything includes preparedness:

*There are checks each shift, making sure the resuscitaires are working, making sure your equipment is all together, you know where the resus bag is, your PPH box, all of those things. You know that there are certain things that you need to tick off each shift. We also have the trainers who do the resus days, there is certain equipment that they always check as well to make sure it's working and things like that. I think basically having regular meetings with the staff so you know what's happening in the unit and doing training days together. It's keeping your own practice as safe as you possibly can. And getting to know people. Being known and getting to know people, it's so much easier to consult with consultants because they know you and you know them. So it's, being known in the area and having a good reputation. (Sandra)*

Rehearsing for the emergency includes the checking of equipment, knowing instantly where everything is and ensuring it is working. This task is taken seriously and attended to each shift. Alongside checking the equipment, there is the knowing one another and being known. Sandra says it is much easier to consult with obstetricians when the knowing is mutual. Amongst all of this, the midwife safeguards her reputation, her preparedness, her attention to readiness for whatever might present in the primary unit. The following excerpt relates to the whole team in the primary unit working together when an emergency arises.

### **Working with the Whole Team**

While the team might be relatively small on any given day or night shift, there is a sense of community with midwives and support workers. Robynne describes the importance of the team working together:

*We make sure that all the staff, be it the cook, the cleaner, the HR clerical, all the midwives, are all part of the property. We work together because sometimes it might be the cleaner that answers our bell. For her to know that she could come and put her hand on a fundus and hold it, while the midwife does something else, is really important for a lot of us. Or that they know how to call me if I'm off duty, or how to call an ambulance. And you might think that that's a silly thing to say. But sometimes when it's happening, and it's been happening, to know that the cook can pick up the phone and call an ambulance. She doesn't have to say all the right words, so long as we get an ambulance. That's what counts at the end of the day. Or we know that they can come and put their finger on top of the neopuff and deliver some air to*

*that baby and get that baby breathing. Sometimes that's all you need to know.*  
(Robynne)

When emergencies happen in primary units, any staff member may be called upon to assist. With fewer people on hand, auxiliary staff might be required to call an ambulance or be directed to help when it is happening all at once. Time is of the essence. When a pair of hands is needed, available hands are called upon. People do whatever is required of them with a focus on the task at hand. To safeguard practice, Robyne has learnt to be innovative, to prioritise and use all resources. Curnow (2011) postulated that wisdom is acquired through a process; however, it can only be acquired in the time the process takes. Therefore wisdom appears to comprise empirical knowledge along with an understanding of the world through experience. The experienced midwife knows to draw people together to play their part.

Wanda describes her experiences of managing the distance factor when working in a primary unit:

*Mostly the distance is okay. If there is a true emergency we can actually get there pretty damn fast. It's scary. The situations that are really scary like a cord prolapse or a massive PPH or a really nasty resus, then you can only do the best that you can and we are really supported well by secondary at those times. You're on that phone to xxx and you've got people here. I have great faith in our team here – both the LMCs and the core staff – because we all know we have to be a step ahead here. So it's scary and your heart beats but I actually do cope well in emergencies, I can stay very calm and methodical and I'm glad about that. Think that helps, my mind switches on and I can think quite clearly through things.* (Wanda)

Wanda describes true emergencies as “scary”. She feels her heart beat because of fear; yet outwardly she portrays coping, calmness and methodical thinking. Wanda balances this scariness with great support from the secondary service personnel. She praises the speed of transfer saying it is “pretty damn fast” in dire situations. She emphasises the need for midwives to be “a step ahead” and has great faith in the team when these rare yet challenging emergency situations arise. Doing one's best will be enough in nearly every situation.

In the same way, Diane emphasises how the team copes during emergencies:

*I guess it is about your confidence, having worked here for so long now you just do what you can do and you think about things when they happen. You*

*just cope and you do what you have to do, and you can only do what you can do, to the best of your ability. You're taught what to do in emergencies and things and you just process it, and do what you can and get the woman and the baby out to a large hospital as soon as possible. I guess that becomes automatic with years of doing it, you just have to work through that, that's all you can do. You can't do anything more. And so you just touch wood, I'm going to touch the table, its okay.*

*I think the emergencies that we get here are like fetal distress, PPHs. With postpartum haemorrhages, we tend to deal with those pretty good by the time they get to the large hospital, we've done everything we can. Retained placentas, things like that, you have a protocol, and you have been through those protocols so often over the years, you just do it. Fetal distress is one of the most stressing because you don't know. You get fetal distress in tertiary units as well and don't know what that baby is going to be like. But here you always worry about the distance. So that for me I guess would be the big one, fetal distress, it is that time span impact upon the outcome of the baby. Generally it is okay, those babies come out fine, most of them, not all. Experience helps you. Again I think having experience at a tertiary unit, because you see a reasonable amount of abnormal. And then I think that helps to recognise when you are in a primary unit that okay now is actually abnormal, you've seen it so you know that it's time to make a move, to act upon something. (Diane)*

During an emergency, it is about doing what you can do, what you have to do, what you have rehearsed doing, to the best of your ability. Diane is steadfast in her pragmatic approach that you can only do what is possible within the primary unit space. She says that acting in the moment becomes automatic with years of experience and adds that you “just touch wood”. She ‘touches wood’ superstitiously once again, hoping for a good outcome in unpredictable situations. She believes primary unit midwives deal with postpartum haemorrhages well. Protocols guide midwifery action during emergencies and midwives rehearse these actions to ensure an automatic response when needed in an emergency.

Diane admits that fetal distress causes her the most worry; the time span distance can impact on the outcome. There is no guarantee of a good outcome for every baby whether in tertiary or primary unit. It is confidence and experience that help to point to the need to move or act immediately. In this critical moment of needing to transfer out, she is aware of the distant position of the primary unit. Bollnow (1961) explained that one's disposition at a particular time has an effect on one's lived-space. Diane's awareness of distance is heightened during an emergency, particularly so with fetal distress and she worries about the time to transfer to the large hospital.

Sandra describes a baby born in poor condition:

*She was a grand multip pregnant with baby number nine. She had settled all the other children before she came in, as they do, and birthed as soon as she arrived. The baby was shocked and white, it just gasped, and it just looked like one of those fish. And everybody in the unit came to help. Even the support workers came to help me resus, and someone said do you want me to dial an ambulance? Everybody as a group just worked together really well because we knew what we had to do, and someone wrote things down. Someone looked after the mum while I did the baby. And we were having to resus that baby as much as we could. We got the paramedics there and we went in the ambulance with a neopuff and kept doing resus all the way to neonatal care. Obviously we kept explaining to the parents what we are doing at the time. I did the cardiac massage and someone maintained the airway for me so that was the main thing. (Sandra)*

Sandra describes a busy woman who had had to prioritise the needs of her children before birthing her ninth baby immediately on arrival at the primary unit. The baby is in a precarious state, gasping and white. Sandra remembers that every person in that unit responded to this emergency and helped appropriately. The baby required cardiac compressions and positive pressure ventilation en-route to the neonatal unit.

*It was a big resus, I can't fault the paramedics because they put the monitor on so we could actually see what the baby's heartbeat was and just helped prompt me when I needed that kind of thing. It was good team work. We did ring the neonatal team and say what we were doing and how we were doing and they just said bring baby in as soon as you possibly can. I think we were doing everything. I just explained the equipment I had and they said, 'Just keep going, just keep going'. Because it is your basic resus that you need to keep going on. You think do I need to do drugs or anything? And they said, 'No just keep going with your neopuff, keep going with your cardiac compressions' – because that's all you can do really. So we got there and when they x-rayed the baby's lungs, there was obviously meconium because the lungs were quite white. Baby did survive thankfully, he did go home and as far as I know was doing fine. So it was a bit scary but again it was the team effort, right down to the support workers who said what can I do to help which I thought was amazing. Because when the emergency bell goes, everybody will go and help. If you're in the tea room you go and help to see if there's something you can do, or you just try and all pitch in really. (Sandra)*

Sandra communicates well with the neonatal team who reinforce continuing with the basics of resuscitation (open airway, effective ventilation and cardiac compressions) and said “just keep going”. The baby’s lung function had been compromised by meconium, but this was only revealed later by radiography. Sandra acknowledges it was “a bit scary” and frightening; yet she is reassured by the team effort, the immediate response from

every worker in that unit. Perhaps there is more pressure undertaking neonatal resuscitation in a primary unit with fewer midwives and no doctors on site. When a baby needs extensive ongoing resuscitation, there are no ‘experts’ down the corridor to relieve the midwives of their responsibility. Nevertheless, Sandra describes the support at the primary unit as amazing because the whole team lends a hand.

### **Recognising Normal and Not Normal**

Primary units are a place for normal labour and birth. Differentiating normal from abnormal is very important in this setting. Kirstin describes being safe within boundaries as safeguarding intrapartum care:

*For me being safe is about understanding my boundaries. Understanding what’s normal makes me be able to be safe to do my job here. Understanding this goes back to my training, I guess from being a student from what we get taught. It’s really clear the boundaries of what’s normal and what’s not. And when you’ve done it time and time and time and time again, you start to get a really good feel for what’s normal and what’s not. How do I know what’s not normal? Again it depends on the scenario that you’ve got but there’s always something that comes up that says this isn’t normal, like a decelerating fetal heart. That might not be the be all and end all, but it starts you thinking what’s going on and makes you look at the bigger picture and there’s always something, there’s meconium if the waters break, or if you’ve got a prolonged labour. There’s always something that starts you going okay, this isn’t in the boundaries of what is considered normal in normal childbirth. We’ve got guidelines for those reasons to give us those kind of parameters to work in with. (Kirstin)*

Kirstin recalls her education where she learnt the boundaries of normal. She also calls on her experience of seeing things time again to alert her to the abnormal. The words “time and time again” repetitively emphasise the importance of accumulative experience. One might ask, how do less experienced midwives recognise normal versus abnormal without accumulation of past experience? Perhaps colleagues and midwife managers need to point to the abnormal? Perhaps less experienced midwives are particularly cautious and therefore might transfer women from the primary unit earlier? Safeguarding thus involves being timely. Kirstin says there is always something that points toward a warning sign, some signal that things are not quite right. She looks beyond one thing and pieces together all the information to create the big picture. She is asking the question: Is this normal or is it not normal? Kirstin reminds the listener that there are guidelines in place with parameters that indicate abnormal (Ministry of Health, 2012a).

When something abnormal is missed, there is concern for consequences. Kirstie describes the problem of not recognising normal from an obstetrician viewpoint:

*Mainly when things go wrong it is when people fail to recognise that things are no longer normal. Recognising when labour is not, is no longer normal; such as recognising failure to progress and recognising it early and not just hanging on there with your fingers crossed. It doesn't really happen here to be honest, it's more other places. You need prompt action for PPHs, prompt resuscitation before the ambulance comes.*

*Where the women have had long first stage and long second stage and been pushing for two hours, and then the midwives ring! Not good. So that for me is recognising when normal is no longer normal. For me, it's about recognising what's normal. So if the woman's fully, and she has a passive descent, and then she's been pushing for an hour, and there has been no advancement (of the fetal head) for that whole hour, and there's been no attempt to determine what position this baby is, and she arrives (at the large hospital) and she's got oedematous and baby is OP (occipito posterior position) and clearly she's made no progress for two hours. To me that's not appropriate and if you've got someone who you've defined as fully and as being OP and they have their passive hour and then they push; if they're not progressing after a good half hour, 40 minutes and you can't see advancement, that's different from the one that's OA (occipito anterior position) and sitting low on the perineum that might just do it. And it's that failure to make that final diagnosis that really irritates me.*

*But for me a VE is not complete until you've defined the position. Because it alters the way you manage second stage. I think if you're the one that has to pull the baby out with a difficult Ventouse, you're more inclined to actually make the diagnosis of the position (laughs). Whereas if you're the midwife, and I might be completely wrong, if you're the midwife that can hand over if it gets too hard, you don't have quite the same drive to define what position it is because someone else will bail you out. I just wonder. For me, this is what I teach my registrars as well; a VE isn't complete until you've defined the position. (Kirstie)*

Kirstie [obstetrician] shoulders responsibility for safeguarding women and babies transferred from primary units when she is on call. She gets frustrated when midwives fail to recognise things are no longer normal and feels that she is left to “bail out” the situation when a midwife hands-over too late. Kirstie describes some midwives “hanging on with fingers crossed” whereby midwives fail to act early upon failure to progress. Kirstie suggests a formula for action; she accepts time is necessary for passive descent (at full dilatation) of the baby's head. She then suggests enabling 30-40 minutes of time for progress during pushing. If there is no advancement of the baby's head during pushing, the woman should be transferred. Kirstie points to the position of baby's head being of utmost important when progress has stalled; the posterior head is problematic and different to an anterior head that is low on the perineum. One might ask: Is there a



disconnect between this obstetrician's viewpoint and some midwives' practice? Perhaps the midwife does not hold the same level of concern about the position of the baby's head? Perhaps the midwife who waits 'too long' believes the woman will progress? Perhaps the midwife's past experience beckons success with normal birth when giving a longer time frame? Perhaps the midwife does not want to 'see' that transferring is the best option when progress is not apparent?

Diane describes the difficult balancing of midwifery decisions intrapartum:

*I think you have to be a bit careful, you can anticipate a problem instead of anticipating it all being normal. So, it's about keeping it all in balance and making sure that you're honest. Because, you're not doing the mum and the baby any favours by normalising something that is a problem. And I just don't do that. (Diane 2)*

Diane tries to ensure that everyday practice is not problem orientated; yet equally mindful not to normalise problems. She succinctly describes the tension, the balancing, the duty to ensure the safeguarding of the mum and baby. Within safeguarding, there is the need to remain honest in this process and not be "normalising something that is a problem". The following data is about making the call to act on problems.

### **Making the Call**

Decision-making is the hallmark of safe care in primary maternity units. Mary describes forward thinking to ensure safety at a primary unit:

*I park that distance aspect in my mind, like I do the whole watching the clock. The thing that I probably struggle with the most is that I have this really deep sense and strong belief that birth is normal, but I'm also aware of my responsibility around ensuring clinical safety for mum and baby. I guess it's a heart and a head thing. Once I've decided that I've got to go, then you just go. So you're constantly thinking, okay, what should I be seeing now, what should have happened by now and why might it not be happening? And the other thing I find helpful at the primary unit is you can always get a second opinion and you can talk things through with colleagues. It can be a no brainer, like a primip who was 5 centimetres and meconium. Another primip that had been niggling for three days with a posterior baby on board and hadn't progressed past 5 centimetres. Again that was quite cut and dry because the history was all there. Everything was normal but after two assessments she hadn't moved past 5 centimetres and so that was kind of like a brief conversation with the staff, consulting and going. (Mary)*

Mary describes the paradox of practising labour care in the primary unit; she emphasises a deep sense and belief that birth is normal yet she feels the pervasive responsibility to ensure clinical safety for the mum and baby. She is conscious of watching for what she should be seeing 'now', what should be happening 'now'. While some decisions to transfer are easily made, Mary values dialogue, the second opinion from colleagues in the primary unit.

Wanda speaks about decision-making and transfer:

*I do think that you are judged by the people, some of the people, every time you transfer. It's analysed what happened out here. So you're always just aware of that and it makes you document so carefully. Sometimes even though you know what your outcome's going to be, you need to ring up the secondary hospital and just say, 'hey, this is what we're doing,' so that they know and you know they know. For example, with an unbooked woman that we haven't got a lot of information on, and you know that by the time you transfer there, that baby is going to be born. And you have to make a call to stay, but, you don't actually know that do you? You only know that from, something in you. That's knowledge and experience I suppose. And it's like do you trust that? Sometimes, you're wrong but, you have to be able to wear that, touch wood!! Touch wood. (Wanda)*

Being judged and having your decision making analysed creates an additional tension for midwives in primary units. When women are not booked for maternity care, ideally a transfer takes place due to a lack of information about potential risk factors. While transferring to the secondary/tertiary hospital is preferred management for unbooked women, the reality is the midwife must make a decision at the time. She makes a call in the moment; shall we go or shall we stay? Will the baby be born in the ambulance on the roadside or motorway while attempting transfer? Wanda says you actually do not know what will happen; nevertheless, you have to "make the call". She says it is important to be trusting of your decision, your judgement. Sometimes the call will be wrong and you have to accept the consequences of that decision.

When a transfer is undertaken, there is a sense of being judged by some people at the secondary/tertiary hospital along with an analysis of the transfer. Feeling judged creates discomfort and often strains relationships between primary unit midwives and those at the obstetric hospital. Anticipation of this judgement forces Wanda to document her decisions very carefully. There are times when she rings the secondary hospital, even though she knows the woman will birth before the transfer can be arranged. Thus the primary unit midwife has to predict, assume, guess and judge the likely outcome. How

do midwives learn to 'make a call', or guesstimate of the time when birth will occur? The midwife's confidence, knowledge and past experience are crucial factors. However, predicting the time of birth and the outcome is always a gamble. The midwife can get it wrong. Like another participant, Wanda touches wood twice. She touches wood for good luck and also to protect herself from bad luck.

Lynn describes a woman having her second baby in challenging circumstances:

*This lady came in, she was having her second baby and was very advanced in labour. She was also very distressed but not distressed with the labour, there was another layer of distress and she felt there was something wrong. I think she was 9 centimetres and some of the way that she was acting looked like transition. She wanted to go to the bathroom so I said, 'right come on, if you're on your feet and you're walking it will help'. She went to the bathroom but she almost got to where she was screaming that she felt that something was wrong, as if her instinct was telling her something and I just thought, well I'm not going to ignore this. She felt she couldn't push and we were going to make this call about transferring, she kept feeling there was something very wrong. Anyway we checked again by VE and there was no descent after 30-45 minutes. She kept saying I'm sure there's something wrong and I thought oh I'm not going to encourage her to do anything else here, she's not in the right place, and so we went up the road. We got up there and she ended up having a ventouse almost immediately, she needed a rotational ventouse. And that was a big learning curve in the sense that it was quite challenging for me to do my assessment, but in my heart I and she knew there was something wrong and it was that intuition that I just thought no, I think we'll go. I think she's right. I have had a couple of experiences with women where something's not quite right for me. (Lynn)*

Lynn recognises that 'something is wrong'. The semblance is transition, the time just prior to a woman birthing normally. Lynn uses her assessment skills and undertakes another vaginal assessment (within an earlier timeframe than usual) to check for progress of labour. When no progress is determined, she makes the decision promptly to transfer. The decision is justified by the need for the obstetrician to undertake an immediate vaginal operative delivery. She suggests it was intuition, yet there are several factors pointing toward something abnormal that guide her decision-making. She safeguards this birth by listening to the woman, anticipating possibilities and by being prepared to transfer in a timely manner. She does not ignore the real fear expressed by the woman that something is not right.

## Leaping Ahead to Safeguard

Another aspect of safeguarding is collegial support in the manner of anticipatory thinking to keep labour and birth safe in primary units. In order to do this, midwives keep looking at the whole picture and continually assessing is this normal or not normal within the context of a primary unit.

Lynn describes coaching a 'newer' midwife:

*Often as a core midwife it's really good for your relationship with a newer midwife to offer support without making anybody feel that what they're doing isn't right. There are times where you may need to step in but also times where you need to just be there quietly in the background. You don't want to put your stamp on anybody as such, yet there is a period of time where you have to all get to know each other.*

*It brings to mind a newer midwife who needed a bit of help and guidance when labour was not progressing. It felt difficult because she didn't always let us know what was going on and I don't know why that was, but I know it's hard sometimes when you're new with a lot of very experienced midwives around the unit. I had two occasions where there was some guidance needed and other midwives had similar situations. I tried to give that guidance in a supportive manner. You could see that progress was really slowing and it was helping her make that decision herself by asking things like: How long do you think the labour has been? Ask her to look back at what has happened, and see when she needs to make that decision to transfer. Because normal straight forward healthy is okay. But I think it's when you have to step out of that, when things are deviating, and you're making a lot of those decisions yourself for the first time. They are big decisions to make. Mostly this guidance happens at the time outside the room. You know you go into the room and say, just checking are you okay? Are things okay? And then a few days later, give some feedback, very quietly in a safe way, because it's hard when you're newly qualified and you want to learn in a safe way. (Lynn)*

This manager is hinting at the meaning of 'support' for the newer midwife. She says one can be there quietly unobtrusively; however, there are times when she has needed to 'step in'. Initially, the newer midwife had been reticent and not communicating the woman's progress to the primary unit core midwives. The manager guides the newer midwife by asking her to review the situation and relook at the time map from the start of labour. She asks her to think about when she needs to make the decision to transfer. The manager is teaching, coaching and safeguarding. When things are not straight forward one needs to take action. The manager says these are big decisions to make, especially when the newer midwife is making these decisions for the first time.

Heidegger (1996) discussed the notion of concern exemplified when one leaps ahead of the other to give 'care' back to the person and/or when one can do for the other, taking over the care by 'leaping in'. Leaping ahead means seeing the situation in advance of the person and freeing him/her to do the job. Such "concern is guided by consideration and tolerance" (p. 115). This manager describes leaping ahead of the newer midwife. Her concern and consideration assists the midwife to review the situation, to act on the slowness of the labour and consider a decision to transfer. There is a sense of guiding and giving responsibility for the care back to the newer midwife. Leaping ahead entails guiding and coaching through concern to enable the other to act decisively in a safe manner. Alternatively during an emergency situation, leaping in might be necessary. Leaping in is akin to domination or taking over from another.

Helenmary continues to exemplify the theme of coaching a less experienced midwife:

*I was looking after a woman with a midwife who hadn't done a lot of births and when the membranes ruptured it was absolutely thick meconium and she said to me, 'well we will have to transfer now', but the woman was 9 centimetres and I said, 'well actually we're not going to. We're actually going to birth this woman here. You and I are going to do this. We're just going to let them know out there that we've got meconium so the other midwife knows that and we can make sure the resus is all set up'. The baby was born absolutely fine, there was no need for resus and we did have normal observations postnatally and all was fine and it was empowering for the woman. She was all set to have this baby in a primary birthing unit, but at 9 centimetres, I think they were wanting to disappear, to be going off to secondary. Now I know that sometimes you look at the safety side of it but actually it was safer to birth her here than in an ambulance. She was a multip, it is safer to birth her here. (Helenmary)*

In this case, Helenmary leapt in and made the decision to stay in the primary unit. Deciding not to transfer might be harder than deciding to go; it takes courage to make this call. Helenmary is weighing up safety and risk, balancing potential outcomes, thinking it is too late to undertake a transfer. She makes 'the call' and makes the right decision; baby is fine. Yet there is always a readiness to act if the baby did require resuscitation.

In addition, Robynne describes guiding a new midwife:

*A new midwife was caring for a gravida 4, she had normal births, good size babies, no issues in the past. She was about 6 centimetres when we came on in the morning. The woman came in at 11 the night before, so in reality she probably should have birthed by now. By lunch time we'd only got to about 8 centimetres. The membranes are still intact and she wasn't drinking that*

*much so, it was just a conversation about why don't we put up some fluids. I talked to the midwife about maybe rupturing membranes, even though the research does say that it only decreases the time by about 20 minutes. Another reason behind rupturing membranes was I wanted to see what colour the liquor was because it had been a long labour for this gravida 4 who normally had about 8 hour labours. So I just coached the midwife. She said, 'look I'm not very good at cannulations'. I said, 'some days I get every line in and other days I don't'. So we did the cannulation together and I just suggested that we took bloods, just in case we had to go up the road. And then, put up some fluids, ruptured her membranes, there's clear liquor which was good. We got her mobile because even though baby's head was engaged it was still a bit high, so just got her mobile and within 45 minutes, we'd had a lovely normal delivery with intact perineum and minimal blood loss. (Robynne)*

Robynne is leaping ahead of the new midwife, coaxing her to consider strategies for progressing this woman's labour; she is concerned that the labour is too long for this multiparous woman and foresees problems. Robynne offers to help the new midwife with skills such as intravenous cannulation and rupturing membranes. She is mindful of the woman's safety and, in turn, is safeguarding the new midwife's practice. She wants the new midwife to adopt strategies to prevent the need to transfer. In this case, the strategies are successful. Both midwives are rewarded by witnessing a "lovely normal birth".

In another situation, a manager describes a midwife who, in this instance, is not keen to accept guidance:

*There is one LMC who probably doesn't take kindly to suggestions. She had a woman having a first baby with an anterior rim for a few hours. And I did suggest that maybe we consulted and she's like, no, we will end up going and then having a birth in the ambulance. She said, 'I'm not going'. So I said, 'oh okay, so put up fluids, get her up, do all of the things'. Then she phoned her practice partner to come in for support, and said to me, 'oh my practice partner's told me I have to consult'. I said, 'okay, is there anything you want me to do while you're consulting?' Of course the consultation was to transfer. So by the time the practice partner got here, we had the ambulance waiting, we had everything ready to go but by then there was a descent peep of the baby's head. She did get me in for part of the pushing and I recommended that we got the woman up because she was on her back. I said try standing or sitting on the toilet because then she can't not push. So we ended up having a nice normal birth here, but we did have a bit of a bleed. It was a good size baby it was about 4.2 kilo for a little primip. It wasn't a huge PPH but enough to wake you up and make you think. We managed the bleed, didn't need to transfer. But I sort of thought that if she had actually listened to me a couple of hours earlier, we did in hindsight have enough time to get to secondary but, it's that tossing up. (Robynne)*

What is behind this LMC being less keen to take advice on this occasion? The manager suggests consultation but the LMC declines this advice. However, the manager – LMC conversation seems to have prompted the LMC to call in her back-up partner. Heidegger (1996) spoke of ‘fearsome’ showing itself as ‘fearing’; meaning that which is feared. Fear has the character of being threatening. In this context, the LMC might be fearing the judgement on transfer to the obstetric hospital, or fearing the birth occurring in a claustrophobic ambulance. Perhaps there is fear in denying the woman an opportunity to birth in the primary unit. The manager continues her narrative:

*I did say to the practice partner look, thank you for suggesting that she consulted because I had already advised that but the LMC had declined to consult. For the practice partner to say that as the very first thing was actually great. The practice partner said, ‘I’ve had a chat with her and said primips that are dragging on, you need to consult’. I said, ‘well thank you for that because, that was my thinking but it’s her lady’. Yes I’m clinically responsible for the overall picture but it’s her lady. I will have a word with that practitioner when I next see her and just ask her where her thinking was at because I know that she had been up most of the night. You don’t know how busy she’d been the day before, so how much of her clinical judgement was still with her. (Robynne)*

In this situation, the back-up LMC and manager both echo their fear of a poor outcome. Heidegger (1996) stated, “We are afraid for the others most of all precisely when he is not afraid and blunders recklessly into what is threatening” (p. 133). Fearing for the other is co-attunement; concern for what might threaten. The manager and back-up midwife address their concern for this LMC who declined the advice from the manager but accepted the same advice from her back-up midwife partner. The manager discusses her overall clinical responsibility for the primary unit, while acknowledging the responsibility for this client is held by the LMC. Nevertheless, in the spirit of safeguarding, the manager intervenes; she suggests a plan for safe care.

This story brings to the fore the thinking of following up this event. The manager is intent on speaking with the LMC. While she expresses empathy for the LMC midwife’s lack of sleep, she remains concerned by her decision-making. In spite of tiredness, or what else might have gone beforehand, the LMC has to safeguard intrapartum care. The following excerpt shows the need to be prepared for whatever might occur.

## Being Thrown into Situations

Midwives in primary maternity units can be ‘thrown’ into situations and need to respond in the moment. Vivienne describes what it is like to ‘manage’ an emergency in a primary unit:

*Our worst resus was a precipitous labour of a breech where the baby was born with the placenta and had Apgars of nought at 1 minute and at 5 minutes. We were doing bagging, endotracheal tube, adrenaline and the whole bit. We even got a line in and gave glucose before the baby went in the helicopter. That baby is absolutely fine, survived beautifully. I stayed with the woman because the LMC went with the helicopter. Those sort of situations are difficult, you don't know the woman, I just got called in ... and had to assist. And then after the baby and LMC had gone, after everyone had taken off, I sort of had to say, 'Oh hello my name's Vivienne and do you mind if I just have a peep and see if we need to do any stitching?' And I had to do suturing; but that was the least of our worries. At the time it's always a bit nerve wracking but you re-play these things and we usually have a good debriefing session afterwards to work out what we could have done better or whatever. (Vivienne)*

Vivienne recalls the precipitous breech birth of baby and placenta. This situation points to placental abruption where the placenta separates prematurely resulting in a lack of oxygen to baby. The situation is perilous because this baby requires resuscitation for over five minutes, which is a significant period of time. While Vivienne describes the situation as the “worst” occasion of undertaking resuscitation, it might alternatively be interpreted as a sterling response to an emergency. Vivienne is called in to assist with this emergency and she speaks of bagging the baby and giving adrenaline. By chance, an experienced neonatal nurse is on hand to insert an intravenous line for glucose administration. While endotracheal intubation is not a skill required of midwives in New Zealand, Vivienne undertakes this action after telephone guidance from a paediatrician at the secondary/tertiary hospital. Once baby is stabilised, the baby is transported via helicopter to a neonatal unit.

Being called to assist a previously unknown woman and baby in an emergency is challenging. Vivienne clearly remembers this situation and admits it is ‘nerve wracking’; her nerves are strained as she tries to assist the outcome for this baby by performing effective resuscitation. What safeguards these situations? Vivienne and colleagues who undertake on-call are in a state of ‘readiness’ to drop everything and respond to an emergency. In this case, Vivienne did not know that she would be asked to insert an endotracheal tube in the absence of a paediatrician or paramedic. She coordinates an



effective resuscitation with a good outcome. Despite the positive outcome, Vivienne says “*we usually have a good debriefing session afterwards to work out what we could have done better or whatever*”. A step by step analysis of the emergency helps to reveal if anything could have been done better thus safeguarding for a future emergency. Debriefing also assists to address notions such as fear, fearsome and dread which are likely to have been experienced during an emergency situation.

The notion of dread is described by Heidegger (1996) not as an isolated occurrence, but something that must constantly tune one to a threat to one’s existence. Dread differs from fear in that fear is of some real thing that can be named, while dread and dreadful are not things or places but the possibility of things. King (1964) explained, “The threat revealed by dread strikes at him solely from himself” (p. 132). Dread is experienced by humans through being ‘thrown’ into being-in-the-world.

King (1964) proposed that a latent, lingering dread motivates preparedness. Dread might be difficult to understand as that of being-in-the-world. It is not of an object to be dreaded, but dreading reveals to one the very nature of one’s thrownness into his/her being-in-the world; the ontological being. This everyday familiarity with homeness can be broken by dread (King, 1964). Within the notion of dread, Heidegger (1996) brings to light a feeling of ‘uncanniness’ where the uncanny reveals the unhomely, or the feeling of not-being-at-home. Vivienne experiences ‘thrownness’ when her sanctuary is disturbed by a call back to the primary unit. This thrownness continued with the need to act for this very sick baby. Inclusive is the dreadful of not getting it right. This dread motivates reflection and re-enactment to do even better at the next emergency. Fear and the notion of dread ensure safeguarding. King (1964) summarised that in the ‘thereness’, Heidegger (1996) spoke of care; being in its positive mode is there as ‘Sorge’ or care. Similarly Gelven (1970) stated that care is the “Being of Dasein” and “for one to ‘be’ is to care” (p. 119). Yet Heidegger also reminds us that ‘care’ comes in indifferent and negligent modes. Without ‘enabling’ and ‘sustaining’ practice, ‘care’ is at risk.

### **Safeguarding Through the Dread**

The following story shows safeguarding through the dread. Wanda describes an event that began with the doorbell ringing in the early hours of the morning in a primary maternity unit:

*It was around 2o'clock in the morning when the doorbell rang. When it's 2o'clock in the morning and the doorbell rings generally you go ah-oh, it's not usually anyone dropping in for a cup of tea! At the front door was clearly a very distressed woman. The woman was saying, 'my baby's coming, my baby's coming' and it was obvious she was in advanced labour. By the time I summoned my colleague from her break and got the woman in to the birthing room, her bag of waters were hanging down (no knickers obviously) and when she got on to the bed that's when I saw the tiny, tiny, tiny tummy. And I thought oh no. No. She was unbooked. We had nothing about her and there were bulging fore waters and no presenting parts at this stage. (Wanda)*

There is dread when the doorbell rings unexpectedly in the middle of the night. A distressed woman announces that her baby is coming. When they reach the birthing room, the midwife notes the tiny abdomen indicating a likely preterm baby. The bag full of amniotic fluid is hanging down from the woman's perineum. Wanda needs to deal with this situation calmly but with haste:

*She had a very, very irate partner; all he was worried about was that she was in pain. And he was saying 'can't you do something for her? She's in pain, can't you see, get some f-----..... pain relief'. I actually had to say, 'stop, stop. I need you to stop, if you can't stop, we need to call the security because we can't have this right now, we need to concentrate on what's happening here because your baby's about to be born'. We know nothing about her. Of course, my colleague is trying, rushing, looking up anything we've got on the computer re her name. She rang an ambulance obviously first. (Wanda)*

To make matters worse, the woman is accompanied by a highly anxious and verbally abusive partner. Wanda takes control and asks him to stop shouting to allow her to find out what is happening. She and her colleague are desperately trying to find details: When is baby due? Has this woman had any antenatal care? What is her past obstetric history? Had she had a previous caesarean? Has she had issues with blood pressure? Meanwhile, the labour rushes on as the midwives attempt to find information:

*The next thing a little foot appears and it's a tiny little foot about the size of a finger. Oh dear Lord. I mean it's amazing what we did in that time because I had the blanket out, the cellophane to wrap baby, the warmer and resuscitaire ready. We had the ambulance arrive. And another foot arrived and I'm always saying hands off, hands off, hands off. The baby was kicking vigorously, another contraction and a little bit more. We saw the baby's abdomen and then nothing, absolutely nothing. We waited for the next contraction in about two minutes and nothing happened. And slowly the feet movement started slowing and it was like ah-oh. I looked at my colleague and said, 'I'm going to have to have hands on' and so I gently got the bag of waters and tried to, just sort of teased it and then 'kapow', everything came. And the reason she'd stopped contracting was because she'd had a complete abruption. The whole placenta, baby, bag of waters, everything came at once. (Wanda)*

Unfortunately, the baby's descent stalls indicating a significant problem. Perhaps the shoulders are obstructed or perhaps the head is deflexed? The midwives watch and wait. As time passes, Wanda makes a decision to put her 'hands on' to carefully assist this breech baby to descend and birth. She uses the phrase 'kapow' to describe the moment when everything 'fell out' into her hands – the baby, placenta and slippery intact bag of waters:

*So we just had to quickly break the waters, this tiny little baby, and his lungs, the sternum, the rib cage, were just completely sucked down, just nothing. He was grey and still and lifeless and I thought, 'oh no, we have lost him', and then he just went "eeeeek". This tiny little squeak. I took him to the resuscitaire. We did the five inflation breaths, well in fact I just put one and one lung opened, then the other lung with the next breath, and lo and behold he starts fighting and starts to pink up. And I just kept doing positive pressure ventilation and he was in really good condition. I wrapped him up in plastic wrap and then in the little blanket and we transported him to tertiary care. And we actually got an email which was really special from the paediatrician saying, 'You did a fantastic job and he arrived in good condition with a temperature of 37.4 and breathing via CPAP (continuous positive airway pressure). We estimate he is about 27 weeks and he is continuing to do well'. So that was amazing that we got that email, that was really, really amazing. It was so incredible when I look back at what we managed to achieve in that 20 minutes. (Wanda)*

Wanda fears a lifeless baby until she hears a semblance of life. She continues to perform resuscitation in her readiness and dread; she is mindful of a poor outcome. Fortunately, the baby 'pinks up' and responds. She assists the baby throughout transfer, maintaining his breathing and warmth during transportation.

Sometime later, a congratulatory email arrives from the paediatrician and provides praise for the excellent resuscitation undertaken by the midwives at the primary unit. Gelven (1970) drew on Heidegger describing the relationships of fellowmen. Relationships change people by enabling one to "see the world of my fellowmen, I see them in a totally different way of 'seeing' in which I see myself as Being-with" (Gelven, p. 58). This 'being-with' encompasses an understanding of fellowmen; the paediatrician understands and congratulates the midwives for safeguarding this baby.

Wanda concludes this story with humility underplaying her skill:

*We shouldn't be working here if we can't do that. It doesn't always necessarily work out that well and sometimes you can't control that. We should be able to move in to auto pilot because of what we learnt and maintained through seeking opportunities and study days. (Wanda)*

Wanda uses the metaphor 'auto-pilot' to describe how she manages and safeguards extraordinary events. If this woman had presented at the tertiary hospital, the expert obstetric doctors and neonatal team would be on hand. In contrast, the midwife in the primary unit needs to be ready, alert and confident in her ability to safeguard mother and baby. Gelven (1970) described Heidegger's future time as the "ground from which guilt, responsibility and the awareness of possibilities all spring" (p. 188). The midwife's experience is of already being thrown in this world by an undiagnosed breech and unexpected resuscitation. Wanda's use of the phrase auto-pilot acknowledges embodied past learning, the ability to act in the present and to foresee what might occur in future.

## **Conclusion**

Midwives in primary units prepare and rehearse for emergencies that might arise; albeit that emergencies are not frequent. There is a reliance on one's own ability and trust in one's colleagues' abilities. It is essential that primary unit midwives practise emergency drills together and practise these in the setting where the reality plays out. Midwife managers are players in safeguarding the care in primary units. Their oversight ensures knowing of what is happening for each woman. This philosophy of concernment continues 24 hours a day whereby the core midwives and LMC midwives work collaboratively to ensure women and babies are safeguarded. Effective team work also safeguards midwives in primary units. In the following chapter, how midwives are sustained to provide labour care in primary units will be revealed.

## **Chapter Eight: Sustaining Labour Care in the Primary Unit Region**

In the first data chapter, being drawn into primary units, keeping faith in normal, building confidence and using tact were illustrated as enabling midwives. Following on, safeguarding was interpreted revealing notions of expecting the unexpected, working with the whole team, recognising normal and not normal, making the call, leaping ahead to safeguard, being thrown into situations and safeguarding through the dread. In this chapter, the third dimension of the research question, ‘what sustains midwives to provide labour care in primary units?’ is addressed. To begin answering this question and in keeping with hermeneutic phenomenological analysis, meanings of sustaining are further explored. Paton (2005) described sustaining as “being respectful of shared humanity and reflective of the beliefs and values” that underpin one’s professional practice (p. 52). Sustaining encompasses that which strengthens and supports midwives, upholding and validating their commitment toward primary units. When midwives are sustained to provide intrapartum care at primary units, their confidence is reinforced, safeguarding is upheld and their work promoting physiological birth is valued. In this study, sustaining is integral for midwives to continue providing labour care in primary units. In this chapter, I will describe how sustaining occurs within the functioning of regions.

Arisaka (1995) explained “the sort of space we deal with in our daily activity is ‘functional’ ... and Heidegger’s term for it is region” (p. 38). Regions are places in which we work and live; our activities are within region. Heidegger says we are never outside ‘*Gegnet*’ or regions, there is belonging as it surrounds us and reveals itself to us as horizon (Dalle Pezze, 2006). Horizon may be understood as a range of vision from a vantage point; “we speak of narrowness of horizon, of the possible expansion of horizon, of the opening up of new horizons” (Gadamer, 2014, p. 313). For the purpose of analysis, regions are considered as relating to maternity settings; the primary maternity unit as region is located in the neighbourhood of a community. The community region shares the space of shops, schools, parks and a hospital. Another region is the secondary or tertiary obstetric hospital; its existence is known by the community region and the primary maternity unit region. People within each region generally know of other regions nearby; relationships influence the functioning between regions that might be near or far. Services interlink regions and one is interdependent upon the other. For example, the

ambulance service provides transport between the primary unit, the community and the secondary/tertiary hospital region.

The majority of an obstetrician's work is within the secondary/tertiary hospital region where their expertise is enmeshed in technology, managing high-risk pregnancy, caesarean birth and other operative procedures. On the other hand, some obstetricians undertake consultation clinics on site at the primary unit region. These obstetricians establish relationships with the community region where pregnant women, partners/husbands, support people and their whānau/family dwell. The obstetrician develops a knowing of the community region comprising human and geographical nuances such as access to health care, road networks and effects of weather and terrain. Their horizon expands beyond that of the secondary/tertiary hospital region. Data will show that these obstetricians modify decision-making regarding birthplace for each individual woman. In this chapter, the following themes are described; Primary unit as region, Dwelling in the community region, The interface of primary and secondary/tertiary regions, Horizons in different regions and Holding sustaining.

### **Primary Unit as Region**

The primary unit as region is a place and space primarily for physiological birth. It is a space with minimal technology. O'Brien (2004) described modern technology as that which imposes upon nature to undermine its ontological integrity. In contrast, the space of a primary unit encourages the ontological; the unfolding and preservation of normal labour and birth. Midwives working in primary units generally embrace the lack of technology because technology has the potential to change the unfolding of labour and birth. O'Brien (2004) stated that Heidegger is "not simply bemoaning the loss of the world of yesteryear in misty-eyed sentimentality" and there is no "demonry of technology" (p. 20). Heidegger possibly had foresight concerning the consequences of overusing technology. While midwives in primary units are reliant upon expertise at the secondary/tertiary hospital region, the distance between the two regions creates a space to foster the ontological integrity of physiological labour and birth.

Sustaining or holding one's belief in physiological birth requires support from like-minded colleagues interlaced with committed leadership. Midwife leaders within

primary unit regions assist sustaining and strengthening of both core and LMC midwives through their approach of showing discernment and wisdom.

Helenmary discusses how she relates to others in the primary unit:

*You need to have good relationships with your LMCs and with your staff so that knowledge is always shared and people feel free to come and tell you what's happening. Because as a manager, I like to know what's happening. I like to know what's happening in every room and I can only know what's happening in all the rooms if I've got good communication. And once I've got that, then information sharing is great. You've got to have information sharing and that people feel comfortable to do that. I think that it has become a culture here that it does happen, because once you've built those relationships and people see how it works, then when I'm not here, it sounds as though it continues to work. I don't know that it works quite as well because when I come back I hear, 'well so and so didn't do this and so and so didn't do that' and I sometimes have to put a few little fires out!*  
(Helenmary)

Good relationships are essential in maternity facilities, particularly in primary units with less people and reliance upon one's midwife colleagues; the primary unit is a space of midwife led care. Helenmary describes needing to know what is happening in every room and, in order for this to be possible, LMC midwives need to feel able to share what is happening during a labour. The LMC midwife might share information in order to gain urgent assistance; requesting an ambulance, assisting with an intravenous line, resuscitating a baby or controlling bleeding during a postpartum haemorrhage. However, more commonly, the LMC midwife will update the core midwife regarding the woman's progress, request assistance at a birth, or perhaps request relief during a lengthy labour. Trusting and inter-reliance enhance honest, free-flowing professional communication. When the LMC midwife does not communicate in a timely way, or 'closes the door', colleagues on the outside lose sight of what is unfolding behind those closed doors.

Open communication fosters neighbourly ambience. The primary unit region is similar to that of a neighbourhood, meaning a space to dwell in nearness (Casey, 2001). In neighbourly nearness, there is a sense of play within conversation; sometimes the conversation is open and warm, at other times it might be reticent or reluctant. When communication between midwives is less than optimum, the manager has to 'put out little fires' to quell festering 'hot spots' that could ignite if left unattended. Leaders need to display courage and use language wisely to create a culture; we see our world through

interpretations of language (Souba & Souba, 2016). Open communication contributes to sustaining midwives which, in turn, sustains safe labour care.

Lynn speaks of supporting one another by ‘keeping an eye out’ and working together:

*I think here there's a lot of really good support of each other, the good the bad... and there's always somebody here who will just keep that little eye out for somebody who you know.... I think it's an ebb and flow thing, sometimes you can see everybody's really motivated. I think a lot of it is job satisfaction. We all have times where we think oh ... but on the whole it is about women and supporting women and I think there's just something about here, I don't see that in every unit. There's something about how all the midwives here work together... I think there's a comfort and there's that comfortableness around everybody and then you come into that and if you are of the same mind, then it's very easy to work here if you know what I mean. We do try and get together and do things and I think that helps, as well. But I don't know, I think this is quite a unique place in some ways. (Lynn)*

Really good support is needed to sustain relationships within the primary unit as region. Primary units as region are a space for neighbourly face-to-face encounters with reciprocal relationships. Casey (2001) explained that if I am neighbour to you, you respond in a neighbourly way to me. Such relations might include concerning-caring, watching out, keeping an eye out for one another during the ebb and flow of working in a primary unit. Sometimes relationships are strong and comforting. At times, relationships are weak with detached conversing. Sometimes, a midwife might retreat from the intimacy of the lived world of neighbourly dwelling and encounters. Nonetheless, the neighbourly nature of the primary unit region prompts action when a person withdraws. There is a concerned ‘keeping an eye out’ for the colleague who might be feeling less engaged with her occupation and colleagues. The neighbourly relationships keeps an eye on ‘somebody’ to keep everyone safe in their role. There is something in the space of the primary unit that is comforting; there is reciprocal giving and taking as colleagues dwell in nearness and attunement to each other. Having similar philosophical beliefs facilitates working together. ‘Comfortableness’ and being ‘of the same mind’ is sustaining and makes working in the primary unit region enjoyable.

Following on from ‘comfortableness’ with one another, Diane says midwives in a primary unit are able to speak up if they are not happy with something:

*We all support each other, LMCs and core midwives and if you see something that you're not happy with, you say something. We all feel like we can make*



*suggestions without taking control. I think it just comes from working together with a group of midwives, for so long, I don't know what other units are like, but for this unit, staff turn over here is not high. The staff have been here and we have worked as a group of colleagues for many years, so you're used to working with each other and you know how each other works really, so that's helpful. (Diane 1)*

Diane describes supportive relationships whereby “if you see something you are not happy with” you speak up. She probably means speaking candidly; making suggestions to another midwife without taking control away from the midwife responsible for intrapartum care. These midwives have developed a knowing of each other's practice, this familiarity provides reassurance and comfortableness with each other. Heidegger spoke of relating to one another as mortals, dwelling with one another in our work, travel, sheltering; the manner of humans relating is within neighbourly dwelling (Grierson, 2010). Working together in primary units is in the manner of human relating.

In the space of primary units, maintaining effective and comfortable relationships with one another is paramount. Helenmary relays an incident of debriefing and de-escalating a situation with a younger midwife:

*Like the other day someone had birthed, there had been thick meconium, the baby needed a full resus. The resus was fine, the baby wasn't transferred and the staff here thought the baby should have been transferred to be assessed by paed (paediatric service). So, I hear about it. The LMC midwife was here that had birthed the baby so I said actually I'm just going to have a little conversation here. So I sat down quietly with the midwife who was a young LMC and said to her, 'tell me about what happened here?' She said, 'well I actually did ring the paediatrician once the resus was finished and he was actually really happy that the baby should stay here'. And she did document that. And I said, 'that's good, what you did was fine, what you did was right. But sometimes the paediatricians don't understand the context of what a primary birthing unit is, and for me I would have liked to have seen that baby reviewed. So it's sometimes the way you word things, so when you're talking to the paediatrician, you do need to say to them, look I would like this baby to be reviewed and if everything is alright then we're happy to bring her back here and do the observations'. And so, it's kind of empowering her, saying yes what you did was fine, you've documented it, you've done this right and so then the staff don't come at me again for that because they know that I've dealt with the situation. (Helenmary)*

In this case, the young LMC had consulted with the paediatric on-call service after the baby was resuscitated successfully. The primary unit manager reassures the LMC that what she did was right but points out that the paediatric on-call service may not fully

understand the context of the primary unit region. They might not appreciate that no medical personnel are on hand if this baby deteriorates in the future. The core midwives in the primary unit are wary, perhaps afraid of the baby deteriorating on their watch. From past experience, they feel assured if the baby is reviewed by a paediatrician to rule out pathology that might contribute to the need for resuscitation.

On the other hand, the young LMC might not want to disrupt the mother baby dyad; she probably does not want to transfer baby to the obstetric hospital region. The LMC midwife may view this baby as being well currently and believe that the baby will remain well. She might not have foresight from past experience to err on the side of caution and request paediatric review of this baby. In the unravelling of this scenario, Helenmary shows 'attunement' of mood wherein the discourse encourages disclosure and discussion with the younger LMC. Her intonation and acoustic perception enhance hearing the story unfold. As Heidegger (1996) described, the essence of listening is that of being open as being-with for the other person. Helenmary is being open and being-with this LMC; she is guiding her practice in a manner that is sustaining. She is mindful of ensuring the LMC remains confident to provide intrapartum care in this primary unit. In order to do so, collaborative and open relationships are sustaining.

Diane describes her experience of interacting with a LMC midwife during a challenging labour:

*One midwife when she first did LMC here had a primip with a long latent phase and then the labour had gone on and on. The woman had got to the point where she wasn't coping and the midwife came out and said, 'oh I need to order an ambulance we need to transfer'. And I sort of said, 'well what have you done?' I said, 'well have you done an ARM?' She said, 'ah not yet' and I said, 'well you need to do that and give her another hour or two because the first thing that will happen when you arrive at secondary is that they will ARM her. If you rupture her membranes, you may have the chance of delivering here'. She said okay, even though the woman wasn't coping and knowing that it would enhance her contractions. The midwife went and did that and two hours later she birthed here. I know that rupturing membranes is not seen as part of normal birth at this stage but sometimes, it is necessary and for that woman, she needed it and it allowed her to birth here which she was really happy about. She didn't have to transfer through to secondary. Some LMCs are really good at asking for advice and some of them aren't so good at asking for advice. It's about, keeping women safe and keeping baby safe and just suggesting that you can try this or try this. (Diane 1)*

Diane suggested considering rupture of membranes for a woman where the labour had “gone on and on” rather than transferring the woman to secondary/tertiary region. The consequences of the advice carry a burden of responsibility; if this does not result in quick progress toward birth of baby, transfer will be necessary. Diane reminds the LMC that this will be the first intervention undertaken at the secondary hospital; midwives and doctors at secondary/tertiary region generally expect that rupture of membranes has occurred prior to transfer.

In this scenario, Diane is ‘leaping in’ determining the care and taking away from the LMC. Nevertheless, her motive is concern. Heidegger (1996) described, a concerned taking care of things. This differs from an indifference of passing one another by. Concernful being-with-one-another requires special ways to come near to them. Working together requires disclosing of oneself, considerateness and tolerance towards colleagues. Upon reflection, Diane acknowledges that rupturing membranes is not seen as part of normal birth at this stage, yet at times it is necessary. She continues to hold belief in normal childbirth; she identifies that this might be straying from normal. For her, there needs to be justification to stray from upholding physiological labour and birth. She states that some LMCs ask for and accept advice, while others do not. Spence and Smythe (2007) said the everyday world involves clinical decision-making with a range of possible consequences; there is a possibility of not making the right decision. These authors recognised that both ‘knowing’ and ‘unknowing’ co-exist within acts of courage. One cannot always be sure that the decision will be the correct one. Diane’s decision of rupturing membranes may or may not result in the woman’s labour progressing. She knows contractions are likely to be more painful. Fortunately, the outcome was good and the woman was “really happy” not to have transferred out of the primary unit.

Lynn offers ‘concernful’ support for newer midwives:

*We are safe and we make things safe. That comes with skill and experience and that intuition that you get as you are comfortable in your practice as a midwife and that should never be forgotten. We need to keep newer midwives protected and able to be supported and feel supported but not over powered if you know what I mean. And give them that and share those skills and it’s the sharing I think that’s probably one of the most important things. (Lynn)*

Sustaining co-exists with safeguarding and making things safe. Being comfortable in one’s practice comes with skill, experience and intuition. These attributes are needed to

“keep newer midwives protected” and/or sheltered in the context of working in primary units. Lynn states you do not want to over-power the newer midwife, but you need to share skills, not be selfish and do everything possible to enhance sustaining of newer midwives. She exemplifies Heidegger’s mode of relating (Vasterling, 2015). Lynne tries never to dominate newer midwives. Instead she shelters them through the everyday dealing with things and other human beings in the world of providing labour care in primary unit.

For Wanda, the people in the primary maternity unit are akin to being family:

*We are often referred to as a family. I think that’s probably why it can also be so challenging sometimes when you’re that close and sometimes there is conflict. We have worked closely together, it’s hard to separate sometimes, the personal and the professional. But I tell you what, when the chips are down and that bell goes, they run from miles and that’s a wonderful knowing that you know they’ll appear from out of the wood work and we do know that. Anyone that’s here will come; you hear a great galloping, thundering herds of elephants that appear from far away, you know that. Knowing your team are behind you yeah. (Wanda)*

Personal and professional relationships blend for midwives dwelling in the primary unit region. Experience of neighbourly togetherness means they are “often referred to as a family” and, as with family, there are times of harmony and times of conflict. Wanda describes conflict as challenging, yet she knows that when an emergency bell goes in the primary unit, her colleagues will “run from miles” to help. The call to respond to an emergency is ingrained. She describes the response to that bell as a “galloping, thundering herd of elephants”; everyone on site will respond. Wanda seems to be describing the connecting, unity and protection of one another in a herd. Within the primary unit region the team is behind you, covering, protecting, and sustaining you. Previous conflict or disagreement is abandoned when the emergency bell goes. Larivée (2014) interpreted Heidegger’s notion of self being always connected to and being-with others. Dasein exists in this connection with others, ‘we-self’ wherein collectively ‘we’ are united in care. The personnel in the primary region unite in emergency situations. Everyone is committed to ensuring practice in the primary unit is sustained.

Sandra further describes helping one another as sustaining:

*The primary unit staff definitely help me, very much the senior staff there. Its support so if you can’t quite make it to do a CTG, they will help you. Because they know the people that need help. And you build that trust up because you*

*know full well that you would help them if they needed it. So senior staff and back-up support. I've got a great back-up partner, I've worked with some great back-up people in the past and know full well if I called them they can help me. And having good family support. My children have grown up knowing mum's a midwife. And you know if they want me to do a particular thing, then I'll try and take the day off for that, but they know full well that I can be out of here within minutes sort of thing. And, having a good home support, makes a huge difference. You need a partner that will support you.*  
(Sandra)

Sandra acknowledges the help from primary unit core midwives, particularly the senior midwives in the unit. There is reciprocal giving, the core midwives assist her and she assists them. She describes building of trust between the staff at the primary unit and with her back-up. The players in her personal life equally support her and know she might have to be out of the house in minutes. Self is always in play with others as Heidegger (1996) stated:

We choose this term to designate 'knowledge of the Self' in a sense which is well understood, ...seizing upon the full disclosedness of Being-in-the-world... and doing so with understanding... entities sight themselves [sichtet 'sich'] only insofar as they have become transparent to themselves...in those items which are constitutive for their existence: their Being-alongside the world and their Being-with Others. (p. 137).

Understanding of self is situated in being-alongside in the world in everydayness. Larivée (2014) explained further that Heidegger's 'self' is not "cut off from the world" but Dasein is within situation "as the being whose care opens the horizon of the world, which is always unfolded with others" (p. 139). Sandra is situated within the horizon of regions where self only unfolds in being-with-other; such as the core midwives who help and support the LMC, the support from her back-up partner, her family and that of the community region. Heidegger acknowledged care as integral to Dasein; being is care, but care is not self-care. Further explanation is provided by Larivée (2014) who stated:

because the human being essentially is care, does not mean that this care is reflexively directed towards the 'interiority' of the self. The care that animates Dasein throws it 'beyond' itself, into the midst of things (das Besorgen) or among others (Fürsorge) but it nevertheless remains certain that care defines Dasein regardless of the orientation that it takes. (pp. 137-138)

Thus, care that is sustaining is not individualistic self-care. The human being as midwife (in her enabled, safeguarded and sustained mode) essentially is care and is always in the midst of things. Being in the midst of things means within the horizons of regions, within

the dwelling space of colleagues, family and community. It ‘works’ when there is a climate of enabling, safeguarding and sustaining.

### **Dwelling in Community Region**

The primary unit region is aligned with the community region. It is nested in a particular community in which the midwives working in the primary unit region reside. Midwife participants revealed they are sustained by the feeling of dwelling and belonging in the community. They described being known and knowing people as their preferred way of practice.

Vivienne describes the LMC midwife role in a rural primary maternity unit:

*Most of our area is rural and small town. I much prefer knowing people, whereas some people like anonymity but I actually prefer, I quite like knowing people. And I really like going to the supermarket and seeing people I birthed years and years later. I find out what’s happening with the kids and sometimes the kids are 20 and 20 years plus! I love going past the school and seeing all the little tackers going off to school with their big bags and things. I just like that whole family concept rather than, being anonymous in a big city. (Vivienne)*

Vivienne likes knowing the people; her area is ‘small town’ wherein anonymity is impossible. She speaks fondly of seeing clients and their children. She notes, with pride, that she was at some of the children’s births over 20 years ago. Being known and knowing people in the area appears to be sustaining. She does not want to be anonymous. She happily shares lived space with her community and values the everydayness of ‘being known’ as the midwife. Vivienne’s professional and private lives are amalgamated.

Bollnow (1961) described the individual’s house and residence as the centre of one’s space; yet the individual does not live alone, his/her space is within a community and the individual has a position within that community. Vivienne’s position in the community is as their midwife. Bollnow referred to a middle point, where the space of the individual, the group and ultimately the nation in which the individual belongs is shared. Vivienne is such a part of the community that her ‘middle point’ of space is not her own but that of midwife. This means being on-call over 24 hour days for the majority of the year, belonging to the community and maintaining her reputation as a trusted midwife. The neighbourhood enables a protected space with trusted relationships, vocation and friendship (Bollnow, 1961). This extended area beyond one’s home (heimat) is known

to Vivienne. She feels no strangeness here because she knows the community, its people and “the little tackers going off to school with their big bags”. She feels safe in this space. The community sustains her and her vocation.

Smythe et al. (2016) described the Warkworth birthing centre (primary maternity unit located north of Auckland) as a trusted place in that community where generations of women have given birth since 1914. The authors were told about a light at the birthing unit that can be seen at night by nearby residents; the light signifies a woman is labouring in that unit. They know a baby is likely to be born and welcomed into the fold of the community region.

Robynne is also very much part of and linked to, the community region:

*I love working in the community that I live in. My outside life is definitely around sports and whānau and children and so for me to be part of somebody's birth, and then watch them grow, and then come back and be part of their child's birth, that is amazing. It makes me feel old! I do believe that the day that I don't enjoy being part of the birth would be the day that I would have to walk away from it. I don't want that day to ever come. I love being a midwife and working here and I'd fight to keep it open for the women who want to birth here. (Robynne)*

Robynne echoes Vivienne's enjoyment of working in a community where one's private and professional life intermingle. She similarly enjoys watching children grow to adulthood when they return to the primary unit to birth their own children. The love of working in this community and being bonded to the parenting-children cycle is sustaining. Spence (2005), drawing from Gadamer, explained that one's horizon is shaped by one's culture and position in society. Robynne's culture and position are further intertwined across the range of vision of community-primary unit regions. The strength of Robynne's relationship with her community is such that she would “fight to keep it open for the women who want to birth here,” thus attesting to the significance of this primary unit as a region that is fully supported by the community that it serves. In a similar manner, Smythe et al. (2016) recognised the belonging of the Warkworth birthing unit to the community and midwives whereby the community rallied to ensure the continuation of this service:

This particular community confidence was reignited in the 1990s when the government funded maternity unit was closed. The local people rallied to ensure there was a new alternative to enable women to birth ‘in this place’ close to family and friends. (p. 29).

Lynn speaks of the loss when a primary unit is closed:

*I think these places are so important. And I hope that they won't be lost because, I was in another place and I came at the time when they closed one of their more sort of primary units and everybody was so disappointed by that. There's potentially politically a lot of power and a lot of pressure, but we have to keep services local for women and unless we can do that, how far would women have to travel if we didn't have anything more local? (Lynn)*

Lynn has experienced closure of a primary unit and understands the widespread disappointment. She is cognisant of politics and pressures, yet believes that local services are essential for women. When women have to travel further to large hospitals, this impacts physiologically, economically and psychologically; they worry about reaching the large hospital in a timely manner for birth – not too early, yet not too late. Midwives like Lynn have a vested interest in primary units. They do not want to see them “lost” because they know they might be lost forever. This vested interest possibly arises out of the connecting that midwives have with both the primary unit region and community region.

Jenny raises the issue of risk should there be closure of primary units:

*Recently there's been some discussion about primary units and were they going to be continued. A couple of the LMCs from the unit said they went to a meeting with [management] and said, 'if you shut those units there will be a protest. We'll be out on the streets'. They were adamant that research supports primary unit birthing for well women is safer than turning up in a busy tertiary unit which is overloaded and the woman could get missed. You could have a disaster just as easily in the tertiary unit, in fact more easily, than if you're out in the primary unit with just one or two people caring for you. It's a risk to go into a big service, to my eyes. (Jenny)*

Commitment to primary units is apparent by the willingness of these LMC midwives to protest “out on the streets”. Jenny reiterates research supporting primary unit birthing for well women as opposed to being in an “overloaded” tertiary unit where, in her opinion, a disaster could be more likely. Smythe et al. (2016) spoke of the place mattering to women and midwives; women appear to form a special bond to the unit, it is a revered place in the community. Jenny believes that the size and busyness of a tertiary unit poses its own risk as a woman could get ‘missed’ or lost in the busyness of the obstetric region.

Diane describes caring for a young woman and experiencing the influence of the community region:



*I remember a lovely young Samoan woman and I talked to her about having her baby at the primary unit. And she was keen but I didn't realise that it was her family that were not keen. I was fairly new to practising in this area and I brought the family in and showed them around the primary unit. When this lovely young woman was about 37 weeks she said to me, 'Aunty said I can have baby at the primary unit'. That was really enlightening for me because that told me who makes the decisions. She had a beautiful birth and Aunty was very involved. She used water, got out of the pool and birthed. In the next year, her sister came in to the primary unit and birthed. And this young mum came back the following year, obviously didn't do contraception too well, and she had a lovely water birth that time. So it was lovely. The biggest challenge is getting people to believe in themselves, to know that if you're healthy this is a good option. I'm not saying the secondary hospital is not okay, it's just not the right place unless they need secondary/tertiary. If we could just take the primary care women out of secondary units, everybody could do their work so much better. (Diane 2)*

Diane remembers taking the young woman's family on a tour of the primary unit. Some months later, the young woman's Auntie gave permission for her niece to labour in the primary unit. The flow on from this 'beautiful' birth, with Auntie involved, resulted in Diane caring for this woman's sister. The young woman returned to the primary unit for a subsequent birth. Diane argues that primary units are the right place for healthy women unless they need the secondary/tertiary region care. The community region needs to trust the primary unit region as the best place for their families to go for labour and birth. Stories of 'good births' fuel trust by the community and help in sustaining intrapartum care in primary unit regions.

Wanda expands on the community linking with the primary unit:

*I think even our own community supports this place, really well. You hear so many families and whānau coming here saying all of our family birth here. My grandma had her baby here. We get four generations, we get elderly people coming here and saying I had my baby, I was even in this room so they're passing that knowledge on too. I think that it is quite a protected place. I was showing a group of visitors the outside furniture, there's not a bit of graffiti on it, this has probably been here since 1956. It, just, doesn't happen here. It's a really respected part of the community and I actually think that also plays a part in the faith of this place that is matched by an experienced staff that believe in the unit. So you've got just this whole culture of, this being a safe place to birth. (Wanda)*

Generations of families are born in the primary unit. The great grandmother remembers the room she gave birth in; some families continue the custom of utilising the primary unit and proudly announce third and fourth generation babies. Wanda speaks of the

respect given to the outdoor furniture surrounding the unit. The community has faith in the unit and experienced staff affirm primary unit region as a safe place to birth.

Sustaining is multi layered and somewhat complex; this primary unit has longevity in the community. In order for the community to continue to support and respect the unit, it must remain a safe haven for birth. The midwives are experienced and believe in upholding physiological birth. Community region needs to retain confidence in the primary unit region. Confidence is crucial to sustaining primary units. In the first data chapter, I referred to the fluctuating nature of confidence. Confidence can be lush or sparse, reinforced or shattered. Confidence in midwives working in primary units can wax and wane. What enables and safeguards this confidence? It depends. Confidence needs to be embedded in the primary unit midwife but is just as necessary in the woman who labours there. Overarching the midwife and woman is the community region that needs to exude confidence in their primary unit.

### **The Interface of Primary and Secondary/Tertiary Regions**

While the primary unit region is favoured as the place for well women, participants acknowledge the safety net of an efficient ambulance service and timely access to secondary/tertiary region. In the ‘good birth’ (Smythe et al., 2016) the woman felt reassured knowing her midwife had transferred a close friend for a caesarean birth. The woman (Jane) felt strengthened by knowing that the midwife’s practice was safe. Jane and other women needed to know the midwife is there to safeguard birth and would not take unnecessary risks at the expense of striving for a normal birth. The midwife in the primary unit must straddle the territory between normal and abnormal and recognise which region each woman needs to be in during the ‘now’ of labouring and birthing. Sarah, an obstetrician, values the experience of LMCs and core midwives in the primary maternity unit:

*We have a very good set of LMCs here and one thing I have found having worked in different units, the staff here are very good at being proactive and looking ahead and thinking about transfer if things are starting to deviate from normal. Other places I’ve worked, there hasn’t always been that philosophy. So a little bit individual LMCs but perhaps also the unit because I am aware that there are core staff here as well and if there is say a new LMC, they know that someone is new and they will become involved. So, there is that back up as well. I guess I feel much more comfortable when I know that it’s an experienced LMC, but I don’t think I have ever said someone shouldn’t birth in a primary birthing unit because of their LMC.*  
(Sarah)

Sarah commends the “very good set of LMCs” and the proactive staff who look ahead and think about transfer when things are starting to deviate from normal. The notion of time is in play; the midwife is anticipating and recognising deviations in good time to enable a timely transfer. If the midwife is too late, the window of opportunity to transfer might be missed. Sarah acknowledges the value of core midwifery staff that are aware of newer LMC midwives and work towards supporting and sheltering a newer LMC. Heidegger (1993) explained the meaning ‘to dwell’ has been lost in language; however a trace of it has been preserved in the German word Nachbar, neighbour. He then speaks of the Nachbarbauer as the ‘near-dweller’, he who dwells nearby”. Dwelling entails working and sheltering (Grierson, 2010). In the nearness of dwelling and being-with, the experienced midwives work with their colleagues as near-dwellers. Sarah says the core staff “know that someone is new and will become involved”. Becoming involved, guiding, assisting, helping and directing are ways of sustaining the newer LMC which in turn is sustaining of the reputation and safety of the primary unit region. Sarah says she has not denied a woman with a minor complication the opportunity to birth in primary unit. Her faith in the midwives is trustful and reassuring. She knows there is always back-up in the primary unit. Smythe et al. (2016) noted that trust is built up over time yet “fragile to the winds of change” (p. 30). Trustful relations are sustaining. Yet trust is fragile. Trust can be lost if the perception of safety in primary regions is lost.

Yvonne echoes the role of experienced midwives:

*We’ve got lots of grand multips, people who have BMIs over 40, people who have had postpartum haemorrhages in the past. But if the women have had rapid labours in the past, there is no point telling them to go to [large hospital] because they’re going to deliver on the motorway. So we just make sure that they’ve got intravenous access and that the midwives are confident to put in intravenous lines and run it, and then we just say it’s okay. And then they have got us to back cover. We’ve never actually got into trouble in all the years that I’ve been there saying okay. But there’s not many that have to deliver at [large hospital] unless they are previous caesareans or tiny babies or something. And you know, they’ve always got the senior midwives or someone with lots of experience around to give you help. You know, the new young LMCs, there’s always somebody to help them out. There’s a bit of sane, sensible stuff going on all the time. (Yvonne)*

Sustaining is further enhanced through the consulting obstetrician knowing the women in the community region who access the primary maternity unit. Many women have had four or more children. Some have very high body mass indices (considered morbid

obesity) and there are those who have rapid labours and will birth on the motorway before reaching the large hospital. Yvonne assists sustaining of LMC midwives by providing “back-cover” whereby she ‘approves’ women with some risk to labour in the primary unit region. She trusts the midwives will be able to achieve intravenous access in a timely manner and that experienced midwives give help to new LMCs. What does back-covering mean? Perhaps it is sheltering the midwife from harsh judgement, absolving the midwife from sole responsibility for the outcome. This obstetrician relates to the community region; her decisions for place of birth are made in this context of knowing the region.

Yvonne elaborates further on the relationship of trust:

*Some obstetricians don't have a very good attitude towards midwives and as soon as the midwife picks up the phone they assume that the midwife is therefore incapable and tells them to transfer the woman in or sends them to clinic for an obstetric review. Whereas what we've got here is we know our midwives. In clinic today I've had three midwives walk into me this afternoon to discuss cases with me. So not only does that mean I know that they are up with the play, because they're asking me these incredible sensible questions about quite complicated problems. But I also know them as people and trust them, so that's a whole different ball game. So if they phone me up when I'm at [large hospital] and ask me about somebody at the primary unit, I don't say well I need to see her now. I know that I trust the information they're giving me, and I don't need to see the woman. And they all know to be honest, 95% of the time they know exactly what to do, they're just covering their backs really. They write these amazing plans for me and all I have to do is see the plan because they're really good midwives. That's because they keep talking as well, so we have an interchange of ideas all the time so if we have something new we've learned at a conference, we tell them. (Yvonne)*

In contrast to an attitude of uncertainty and lack of trust in the midwife's capability, there is a knowing in the obstetrician-midwife relationship in this primary unit. Yvonne applauds the midwives she interacts with, commends their management plans and says they are “up with the play” in planning care for women with complications. Knowing the midwives as people and trusting them makes it a different ‘ball game’. Gadamer (2014) recognised the mobility in play with to-and-fro moves and countermoves; “the particular nature of a game lies in the rules and regulations that prescribe the way...” (p. 111). There is to-and-fro in the play of communicating; a respectful relating that enhances the spirit of play. Rules for midwife-obstetrician consultation are entrenched in the Referral Guidelines (Ministry of Health, 2012a). Yvonne says that 95% of the time the midwife knows exactly what to do and communicates the plan of action. This affirmation in the

midwife's ability to 'manage' risk factors might astonish some critics. How is this trusting relationship fostered and bolstered? Yvonne explains the connection by saying *"they keep talking as well so we have an interchange of ideas all the time, so if we have something new we've learned at a conference, we tell them"*. The interchange of ideas, dialogue, sharing of new information, all assist in sustaining these midwives to continue providing intrapartum care in this primary unit region.

Kirstie emphasises knowing and being known and, like Wanda, speaks of the family atmosphere:

*We are unique in that we know our LMCs, we know our core midwives here. We know that they're going to be followed up; scans are going to be followed up or a blood pressure is going to be followed up, I know who that is. It's not just some random name in the ether that might not you know. I know the follow up is going to happen and I know they will ring if there's going to be a problem so I try to tell the registrars that we've got a unique little family here. And the midwives sometimes ring during the week or if they've got issues. They have got good leadership here I think and they know they've got the support of the clinic. I think. You would have to ask them. (Kirstie)*

Knowing and relating appear to be crucial in providing safe care and crucial to sustaining midwives. Kirstie emphasises "we know" our LMCs, our core midwives. A sense of ownership abounds with the use of "our" and, contrasting this, knowing 'some random name in the ether'. Ether is akin to something disappearing as the vapour is colourless, untraceable once released in the air. In contrast to something disappearing, Kirstie knows something will be followed up; she teaches the registrars about the "unique little family here" where the midwives will ring any day of the week if they need guidance with a problem. Good leadership by senior midwives is acknowledged and midwives know they have support from the obstetricians.

Sarah juggles the decision-making regarding place of birth with multiple factors that she considers in unison with the woman and LMC:

*I guess [place of birth] depends on the whole scenario with the woman and maybe then the individual LMC might come into play as well. I definitely support the philosophy of having your midwife antenatally, intrapartum and postnatally and so if by me making women go through to the [large hospital] means they won't have their LMC, then that may influence me a little bit if it were a little bit borderline decision. Because the women then lose that continuity of care in labour if I make them go through to [the large hospital]. So that's another thing that they lose and potentially, because our belief is that having that type of care is beneficial to women, they're then disadvantaged. So I have to weigh up the small risk of the moderate PPH*

*(postpartum haemorrhage) against what they would lose by not having their LMC.*

*I guess I try to communicate with LMCs so if something isn't obviously straightforward I would often phone them rather than just rely on a letter. Often they're here and so it's very easy to talk to them anyway, physically talk to them, I guess putting advice and checking with them. I guess if there is one that it could go either way, I would check with the midwife how comfortable she is with [the woman] birthing here. If the midwife were saying, "well actually I'm not comfortable", I would then encourage the woman to go through to [the large hospital]. So it becomes a bit of a team approach. I try to avoid saying something completely different from the midwife unless I really feel strongly that they are not recommending safe care but that doesn't really happen. (Sarah)*

Sarah describes the complexity of her decision-making in relation to 'borderline' scenarios as to the region in which the woman is best to birth. She expresses commitment for continuity of care; therefore, she is influenced by whether or not the LMC midwife will be able to follow through care at the secondary/tertiary region. She knows that if the LMC does not work outside of primary unit region then the woman loses continuity of carer intrapartum. In these cases, she juggles the risk of a woman having a moderate postpartum haemorrhage at the primary unit versus the woman losing the opportunity for continuity of care by a known midwife during her labour. Sarah describes communicating directly with the LMC wherever possible; she says it is "putting advice and checking with them", illustrating a collegial obstetrician–midwife discussion that often involves negotiation. She checks the LMC's comfort with managing a particular woman at the primary maternity unit and encourages transfer to the secondary/tertiary hospital if necessary. Sarah's approach strongly exemplifies 'sustaining'; her obstetric consultation protects and promotes continuity of care, her communication supports, protects and shelters the LMC midwife, her collegiality shares responsibility thus sustaining and upholding the midwife's role. LMC midwives in primary maternity unit region need this style of sustaining to keep providing intrapartum care.

### **Horizons in Different Regions**

Gadamer (2014) described having an open horizon as being able to see beyond what is nearby. Gadamer is arguing that looking beyond what is close at hand enables deeper understanding and a greater capacity to understand the larger whole. Within regions, there is benefit in seeing beyond one's own perimeter. The primary unit midwife needs to recognise when the expertise of others is required. The ambulance needs to prioritise

transferring while negotiating commuter traffic. The secondary/tertiary hospital region needs understanding of the context and accommodating another woman into the birthing area.

Some participants shared stories of interactions between regions with these experiences being foremost in their thinking. Kirstin describes her horizon of providing labour care in a primary unit:

*I think we all really support each other in working primary. We make sure people are aware that this is what we do and we do it well, and we specialise in doing primary. Like, obstetricians specialise in doing secondary and the core secondary midwives specialise in doing their thing and we specialise in doing this. I think it's undervalued by the secondary facilities for sure. But I think as a group out here, we are very good at encouraging each other's women and everyone else that we talk to that this is what we all do really, really well. Even if people ring me that I can't take on, if I've got enough women already, it's like no matter who the woman chooses out here, she will get a good midwife. Because we all do work very similarly like with the same philosophy regarding primary anyway. I have only ever done primary. I don't do secondary services. It just blurs the lines and once you start blurring it for one woman then it's really hard, I just don't think it's fair to do some and not others. (Kirstin)*

Kirstin describes primary unit midwives as specialising in their field, similar to obstetricians specialising in secondary care and some core midwives specialising in secondary service region. Kirstin believes that providing care in primary units is undervalued by the secondary/tertiary region, yet contrasts this with utmost cohesiveness between midwives “out here” who work with the same philosophy. Kirstin says, “it just blurs the lines” to try and do secondary care. For her, an imaginary line separates primary region and secondary regions. Crossing the invisible line to secondary/tertiary region is another horizon wherein services are different. The philosophy of normal birth might not be held with the same vigour in secondary region because the functioning in that region is more commonly with complications and use of technology.

Heidegger (1977) described technology and links *technē* (activities and skills) with the word *episteme*; both words translate as knowing in the widest sense; meaning to be entirely at home in something, to understand and be expert in it. Kirstin articulates expertise / knowing in the primary unit region that differs to skills of midwives in the secondary/tertiary hospital region. Midwives in the primary unit region uphold normal birth in everydayness, this is their expertise. Midwives in the secondary/tertiary region

uphold normal birth whenever possible, yet they have to be skilled with the everydayness of epidural analgesia, intravenous lines, syntocinon pumps and caring for women with complications such as diabetes, preeclampsia, large or small babies. Heidegger (1977) described modern technology in a sense of revealing, 'unconcealment', recognising where the technology sets to challenge or change. How can this relate to care during labour? Heidegger commented, "Only when we allow our attention to rest on this fundamental characteristic does that which is new in modern technology show itself to us" (p. 6). How have we set upon birth to challenge and change its normal processes? Some might say that the region of the obstetric hospital changed birth from home-like surroundings to an environment driven by time constraints and interventions (M. Hunter, 2000; Walsh, 2006b). This discussion is not to judge or favour one region over another. Heidegger acknowledged that man is challenged to exploit the energies of nature and progress occurs in this realm of technological activity. Thinking and reflecting on skills and technological activity brings to light the everydayness of midwives providing intrapartum care in regions. For Kirstin, her expertise in promoting 'normal' birth in primary unit regions is sustaining.

Another midwife described some tension when needing to consult with an obstetrician at the secondary/tertiary hospital:

*I don't like consulting that often because some are better than others. Some of them are really pleasant to speak to and they seem to treat you like you're somebody who might have some common sense. And then there's a couple of them, it might just be their phone manner is worse than they are in person, but with some, I feel like oh, it's not you is it?! But, you just have to toughen up don't you? The conversation has to be had. Consulting with an obstetrician is not something you can pick and choose. You don't do it just because you feel like it. You do it because you have to, so you just do it. Like the response one time with one obstetrician was really off putting, like 'well what are you going to do about it?' And I'm thinking well actually I usually do have a plan. I have an assumption in mind of what I think they're going to say, which is what I tend to say to the obstetrician and then they usually say 'yes well that's fair enough send her in'. But it's probably just their manner, but I find it just not helpful. (Mary)*

The midwife describes feeling apprehensive when telephoning an obstetrician. Some are pleasant and she feels acknowledged for having common sense. In contrast, others have an abrupt or curt phone manner. However, she does not recoil from the process of consultation; she says "the conversation has to be had" and "consulting with an obstetrician is not something you can pick and choose", "you do it because you have to".



She suggested a personal need “to toughen up” when consulting with some obstetricians. What is happening here? What makes some relationships less than helpful? When consultation processes are difficult, the midwife might avoid or delay a consultation to avoid feeling afraid. The concern with a delayed consultation is concern for the detriment of safe care. Knowing each other and care for ‘they-self’ enhances good communication. Although it is impossible for every obstetrician and midwife to know each other, a spirit of relating well between regions and the expansion of one’s horizon to include another region is likely to enhance neighbourly relations.

Another participant describes the importance of listening:

*I often hear, you know awful conversations go on with anxious obstetricians or registrars, just send them in, send them in, medicalising everything, without really listening and thinking it through. So I think, listening to actually hear what the story is and to give appropriate advice. (Yvonne)*

When listening is not happening in an attuned manner, obstetricians and registrars can become anxious and direct that the women be sent in to the obstetric region. There is no ‘real listening’ and attunement with the other in this moment. For successful communication, the midwife needs confidence to communicate clearly and articulate a proposed plan. The obstetrician also needs to have confidence in the midwife in order to listen attentively and feel less anxious about what might potentially go wrong in the primary region.

Midwives and obstetricians are influenced by past, present and future time. In this instance an obstetrician describes a situation where referral did not occur in timely manner:

*We had a woman with thrombocytopenia and she told the midwife she had something wrong with her platelets; the midwife ignored it completely. Anyway, she survived which I suppose reinforced to the midwives it was okay, but not a good plan. So yes, we follow it through. (Obstetrician)*

The obstetrician describes a woman with low platelets and vulnerable to problems related to blood clotting. The midwife allegedly ignored the condition and the woman “survived” but the obstetrician was unhappy with the lack of a timely referral prior to the woman commencing labour. The obstetrician expresses concern that when someone ‘survives’, or a potential disaster is averted, the seriousness of the woman’s condition is dismissed. Early consultation ensures a plan for management and safe care.

Obstetricians who consult in primary regions teach registrars about the functioning of these units:

*So I explained to the registrars a little bit more about how it actually is here and the fact that birthing in the ambulance is not ideal either. Birthing in the unit would be better than birthing in an ambulance ... I guess, because registrars are very medically orientated and until you've sort of got your medical confidence, it's less easy to be reassuring and supportive. I think it's only really by working with them and them seeing how you do it, and gaining in their own confidence. It works better when senior registrars consult in the primary unit because otherwise all the women are booked to birth at [secondary/tertiary hospital] so I think it is good experience in that sense. (Sarah)*

The obstetrician states that registrars tend to be medically orientated and more inclined to recommend that women birth in the secondary/tertiary hospital. However, there is a paradox in sending women with risk factors to birth out of their region. Some of the women will birth in the ambulance or on the roadside which is less safe than in the primary unit. The juggling, weighing up of decisions and safeguarding needs to heed understandings of space and distance. With a growing of confidence, the registrar becomes more reassuring and supportive toward the primary unit as a birthplace. The notion of confidence appears akin to that needed by midwives providing labour care in primary units. Perhaps there are similarities in how confidence is enabled for both registrars and midwives?

The following data reinforces that good collegial relationships and referrals happen:

*Some consultants are very good. With this woman, she really wanted a water birth but the obstetrician was thinking because of her age and slowing of baby's growth, she should birth at secondary and would rather have her induced. That obstetrician phoned me, which I thought was really kind, rather than just sending a piece of paper. The obstetrician said, if the woman won't accept induction now, then I would recommend induction at term and birth at secondary. The obstetrician had recognised the fact that perhaps a woman who wants a water birth at primary unit may not immediately accept the induction and birth at secondary viewpoint. And I found that really affirming of the woman. I rang the obstetrician with the woman sitting next to me, and said this woman wants to go to term and we would like, if everything remains normal, because I mean the Doppler, liquor volume, everything else was normal, we would like to birth at primary. It turned out that although we tried everything she did have to be induced, but once she went in, she had a baby quite quickly. (Mary)*

The story describes a “very good” consultant who showed kindness by taking the time to speak personally with the midwife regarding the woman’s birth plan and place of birth. The obstetrician takes into account the woman’s viewpoint and the chance of her declining an immediate induction. Further to this, the obstetrician offers an alternative suggestion that might be more acceptable to the woman. The midwife believed the obstetrician was affirming of the woman and felt affirmed by being able to negotiate a different pathway for this woman. Kindness is sustaining of work in primary unit regions.

Transferring a woman involves work in the primary region that might be invisible at the obstetric hospital region:

*I guess for me when the woman arrived, you know acutely that this needs to start moving and it is really about making sure the team that come to help, start working really fast with you. So even if the ambulance doesn’t come, and the transfer doesn’t happen as fast as you’d like, all the other stuff is going on that needs to be done. Because we had three of us in there pretty much straight away after I did her temperature and it was not good. I need to start making some calls. It’s like you just get on with it. Obviously it’s my role as the LMC to make sure that stuff’s happening; you need to get her on the CTG, you need to get a line in, I’m ringing the obstetric team, ringing the ambulance. It was just talking to the ambulance about making sure that they knew I needed them there now. Because once the CTG started, the baby was not happy either, so I’m like okay this is stepping up a notch. I just rang the obstetrician, said this is what’s happening, we’re coming. It wasn’t a real conversation about what’s why, or if we’re good, it’s we are moving, this is what’s happening. Rang the charge midwife to let her know we’re on our way. And I always ask how far away the ambulance is, coming as well so I can get in my head around how much time I’m going to have to deal with whatever in the meantime. That’s probably one of the things I always ask as well and make sure that I’m getting what I need there as fast as I can. The ambulance are a lot busier that makes me very aware of time and how long it will be before we get to where we need to be. That is what it is. That’s part of what we have to deal with and do what I can do in the meantime. (Kirstin)*

In this narrative, Kirstin is ‘thrown into the world’ of needing to act urgently to move a woman out of the primary unit region. She summons assistance and asks how far away an ambulance is in order to gauge the length of time she will be waiting. During waiting time, Kirstin needs to “get her head around how much time I’m going to have to deal with whatever in the meantime”. The ‘meantime’ is an unknown entity; she does not know what might happen in the waiting time; this is anticipatory time, the time where distance is felt between the primary region, between the time to get an ambulance and undertake transport to the secondary/tertiary hospital region. She accepts the

responsibility of managing the situation until handover, yet the tension is tangible. She says “because once the CTG started, the baby was not happy either, so I’m like, okay this is stepping up a notch”. Her attention and concern with time is situated in the ‘now’; meaning when action must be initiated in consequence (Kaelin, 1989). Kirstin initiates actions such as fetal monitoring, intravenous fluids and communicating precisely with the obstetrician and charge midwife to say “we’re coming” without a protracted conversation providing rationale. The acting in the ‘now’ is the time from ‘now to then’ when actions are enmeshed in consequence and timeliness.

### **Holding Sustaining**

What else is sustaining for midwives who provide intrapartum care in primary maternity units? Sandra reflects on her everyday working:

*I think it’s the women. It’s the women. It’s sharing their experiences and birth is never boring. You know it doesn’t matter how many years you’ve done it, you can do an all-night and an all-day and you eventually get that baby out and it’s seeing how you’ve helped them through from not knowing anything really, right the way through to discharging them at the end of 5, 6 weeks as a confident mum and it’s that sustainability, that’s why you do it. Because you’ve guided, you’ve helped, you’ve kept that woman going sometimes when she’s not felt like carrying on, and birthing without pain relief sometimes, (Sandra).*

Sandra argues that the women are sustaining of her practice, whether it be an all-night and all-day labour, or working with them through to discharge. She says it is achieving birth “without pain relief sometimes” suggesting that physiological births remain memorable, but are not exclusive to one’s archives of births that sustain.

For Yvonne, she views the team as the ‘glue’ that holds primary unit birthing together:

*It’s just the combination of midwives and having a really interested team of obstetricians who work with those midwives. The team, a team, it’s always, only a team isn’t it? It’s just a team. Everybody knowing everybody and trusting them. It’s just trust. Because the midwives trusted the obstetricians to make the decision and the obstetricians trusted the midwives. The obstetricians would say to the midwives, you keep the women there and deliver them and the midwives know when to transfer them. (Yvonne)*

Yvonne proposes a “really interested team” of obstetricians and midwives working collaboratively towards the same thing, trusting, knowing each other and knowing when

to transfer. The vexed notion of knowing with regard to transfer is embedded in timeliness. Gelven (1970) explained that Heidegger's description of present time relates to carrying out an action. Present time is influenced by past time and future time; present time is likely unnoticed unless one is performing actions or in the midst of a situation. When a decision is made for transfer, the midwife anticipates future-time and that guides action in the 'now'. Gelven said the existence of care involves a projection of possibilities; being ahead of itself as future time (guilt, responsibility and awareness of possibilities), to be already in a world because of ontological past (one's significance of thrown in to the world is revealed) and to be alongside other beings as situations or doing actions. When caring for women in the primary unit region, the midwife is aware of possibilities such as failure to progress, fetal distress, or malposition of the baby, as some examples. Past time includes times where the midwife has been 'thrown' into a situation where time became significant. Time as 'in the moment' is the moment of actions driven by the anticipation of future. Actions such as inserting an intravenous line, taking blood from the woman for 'group and hold' and giving the woman gastric neutralising medication (in preparation for a possible caesarean birth) is acting with foresight. The midwife has a knowing, foresight of expectations in the secondary/tertiary region; this drives her actions prior to transferring women. The 'right' actions generally result in a more convivial reception by those in the secondary/tertiary hospital region.

Jenny, a midwife with experience across the regions describes the 'mattering' and binding of relationships:

*You know what I really think matters, really being collegially professional, having good relationships with LMCs. They know if they call, we work together very closely. You have to. And if you've got something happening with the woman you ring them up. Or maybe if its 9o'clock at night, should we ring the LMC now? Oh we had better not, I think it will be alright, I think we will just change the plan or whatever it is you need to do with the woman. But you are doing it with the LMC who's got the primary responsibility but she's not got the only responsibility. Has she? The woman is not in the service just with one person looking after her. She's in a public health service that we are all in there for her. It's very different in primary to secondary/tertiary, yes! We haven't got another three hours to explain that.*

*Well it's just friendliness and its trust. I mean there are people there that I wouldn't socialise with. That's okay. But professionally, you've got to be a friendly professional. You've just got to be there for each other and chat, good morning, how are you doing, how's your day been. Listen to the fact that they've been up with three women in the night. Its relationships Marion*

*isn't it? It's just that's what it's based on. That's how those units function.*  
(Jenny)

Once again, the mattering is in the showing of neighbourly relationships between colleagues working closely together. Jenny describes the self with care for others, by not disturbing her LMC colleague at nine o'clock at night. There is shared responsibility for the woman; she is in a public health service. The primary responsibility for a woman rests with the LMC. However, Jenny points to the responsibility of all providers. Being there for each other reinforces trusting relationships. Once again, the care portrayed within Dasein is care among others (Fürsorge) (Heidegger, 1993).

Helenmary proposes that some LMCs are feeling uncomfortable with providing intrapartum care in primary units:

*I guess the only thing that I would add is I just wish more women could actually experience primary birthing units. I don't think that a lot of women are given opportunities to do that and that's really sad. So it is trying to reach out to LMCs that feel uncomfortable with primary birthing and getting them back to feeling comfortable. Because I really believe that we are the guardians of normal birth and we have to get back to that. And I think there are midwives that feel so uncomfortable in that environment which is a shame.* (Helenmary)

Helenmary describes a need to 'reach out' to LMCs who feel uncomfortable with working intrapartum in the primary unit region. 'Reaching out' entails supporting, relating and showing care 'with' LMCs in order to assist their being comfortable. She reiterates "we are the guardians of normal birth and we have to get back to that". The primary maternity unit is the place and space for sustaining physiological labour and birth. Midwives need to be confident to provide intrapartum care in this space or sustaining such labour care might be lost.

## **Conclusion**

Sustaining intrapartum care in the primary maternity unit region means that midwives are supported and feel comfortable with working at distance from the secondary/tertiary hospital region. The reputation of the primary unit as a safe place for labour and birth is essential. Data in this chapter reveals that sustaining occurs through colleagues speaking out, keeping an eye on one another and working in care with each other. Other regions can either contribute to sustaining or potentially de-stabilise sustaining of labour care in primary units. Secondary/tertiary hospital regions provide the next level of care when

complications arise. All regions rely on an effective timely ambulance service for transfer. One might question whether the secondary/tertiary hospital region assists in sustaining midwives to provide labour care in primary unit regions? Findings in this study reveal the multiple aspects of sustaining. Obstetricians who provide consultant clinics in primary units assist sustaining intrapartum care in primary regions through understandings and relationships. Obstetricians who portray collegial relationships, kindness and openness during consultation processes similarly assist with sustaining. Transfer processes that occur in a timely, blameless and accepting manner assist with sustaining midwives in primary unit regions. Enabling, safeguarding and sustaining have been presented in the three data chapters to reveal the depth of interpretations. Nevertheless, there is interconnecting; enabling, safeguarding and sustaining are insufficient as single entities. These notions are braided into the 'how' of midwives providing labour care in primary units. Together, labour care 'works'. Further elaboration of this mingling occurs in the discussion chapter to follow.

## **Chapter Nine: Drawing the Findings Together**

### **Introduction**

In this concluding chapter, the findings from my research question: What enables, safeguards and sustains midwives to provide labour care in primary units in Aotearoa-New Zealand; what makes it work are drawn together, revealing the new and interwoven insights. The findings of the whole research project will be summarised and discussed in relation both to extant and philosophical literature. I conclude with the recommendations for practice, education and further research.

### **Drawing together Past, Present, Future.**

From the outset of this study I have been open to my pre-understandings. I came to this study with a belief in primary units as safe and appropriate places for women, without complications, to birth. I conclude this study confirming this belief with new and deeper understanding about what enables, safeguards and sustains the midwives who undertake labour care in primary units. I anticipated that midwives in primary units would hold a firm conviction of valuing normal labour and birth in these units and, indeed, this was so. To my surprise, similar sentiments were held by the obstetrician participants who provided consultant clinics in these stand-alone units. We all share concerns regarding the potential closure of primary units. Historically, the closing of a primary unit means a loss of place/space that enables normal birth to flourish.

Primary units in Aotearoa-New Zealand are public places ‘there’ for normal labour and birth; they provide a middle ground between the high-tech secondary/tertiary hospitals and the private realm of a woman’s home. However, as shown in Chapter One, the numbers of women who birth in primary units has declined. While research evidence shows less interventions for women who birth in primary units and affirms that outcomes for mothers and babies are safe, these findings do not appear to have changed the patronage of primary units. Rogers et al. (2015) were taken aback that midwives did not believe the outcomes from robust studies regarding birthplace, until participating in seminars where the evidence was presented showing safety of midwife-led units. It is beyond the scope of this study to identify why midwives and/or doctors do not believe primary units are safe for labour. Similarly, it is beyond the scope of this study to answer questions about the steady decline of births in primary units. The findings of this study



point clearly to what enables, safeguards and sustains midwives to provide labour care in primary units.

There is an intertwining and connectedness with enabling, safeguarding and sustaining: in synergy they encompass the values, practices and interconnections that make midwives care of women in labour 'work'. In speaking of the findings, what has been brought to light is shown in its wholeness. Enabling, safeguarding and sustaining are three interlinked notions; the wholeness of their interwovenness-at-work reveals more than each part.

Throughout this hermeneutic phenomenological study, the 'how' of enabling, safeguarding and sustaining midwives to provide labour care in primary units comes to the fore. Insights reveal that midwives working in primary units make the complexity of their work look simple; their way of working during labour upholds normal birth. These midwives spoke of being keepers of normal birth. There is a simplicity in the craft of working with the straightforwardness of birth yet, paradoxically, there is sophistication in the safeguarding. The paradox of working with labour unfolding alongside the safeguarding of labour in primary units is an important finding linked with the notion of confidence. This study reveals that the midwives and obstetricians who support primary units know the deep importance of preserving and protecting the space where women are free to birth without intervention; birth has been occurring in such spaces for generations.

The findings from this study coalesce in ways that matter. Arisaka (1995) drew upon Heidegger's notion of regions wherein an inherent feature of space is its functionality. Walking into a secondary/tertiary hospital is akin to walking into a space of technology that is already there. In contrast, walking into a primary unit is a space preserved for normal labour and birth. Arisaka stated that regions determine where things belong; our actions are directional according to the relevant region. When calmness and 'normality' prevail, the primary region stands on its own and the space is encountered as near and neighbourly. It is a space that enables, sustains and safeguards normal birth. When problems present or an emergency occurs, there is a facing toward the direction of the secondary/tertiary hospital region. The secondary/tertiary space is sought out to provide urgent expertise and technology. Arisaka (1995) described the concept of 'equiprimordiality' whereby regions are considered to be mutually interdependent; one cannot exist without the other and the relation is non-hierarchical. While regions have

different functions, there is connectedness to the whole. The provision of maternity services across regions needs to be viewed as mutually interdependent and non-hierarchical; primary units have an essential function in providing maternity services for communities.

### **Thesis of the Thesis: Drawing on Hermeneutic Phenomenological Insights**

The all-encompassing original finding from this study is that midwives need a distinct mode of confidence to provide labour care in the space of primary units. I have named this 'confidence-as-conviction'. Aristotle proposed that a person with an excess of confidence is rash while a person who exceeds in fear lacks confidence. However, when confidence is maintained in its proper limits, confidence is conviction (Rotenstreich, 1972). To function in the primary unit, a midwife cannot be pre-occupied with fear, nor can the midwife be over confident and thus act rashly. Confidence-as-conviction is the careful balancing of the confidence necessary to provide labour care in primary units. This mode of confidence cannot be grown through experience in large obstetric hospitals. It is a mode of confidence uniquely acquired through practising in the primary unit.

Confidence-as-conviction arises through working in the place/space of primary units. It reinforces the midwife's faith and trust in normal birth. In the neighbourly dwelling of the primary unit, there is a mood of trusting oneself and the team. The midwives watch out for each other and speak up in a manner of concerned care. They embody concernment rather than indifference (Heidegger, 1996). Midwife managers know what is happening in the everydayness of the unit and, in doing so, they keep safeguarding the women, the midwives and the reputation of the primary unit. There is a balancing of keeping things normal along with leaping ahead/leaping in when things stray from the boundaries of 'normal', or an emergency occurs.

Further to confidence-as-conviction, midwives demonstrate 'tact in the moment'. This tact is not a diplomatic tact or virtue. It is a knowing tact of practice wisdom (phronesis) embedded in the midwife's attunement and confidence in the primary unit. The midwife knows the right action to take in each individual situation in a way that is not rule-bound. Tact in the moment is a way of showing special sensitivity; it is not a pre-learned, step by step procedure (Gadamer, 2014).

Midwives in primary units must expect the unexpected. They rehearse emergencies in this space and value the trusting in the team. Emergency drills and workshops are more relevant when held in the setting of primary units. When an emergency arises, the midwives draw on these skills and work together as a team following practised guidelines. It is of utmost importance that midwives in primary units know how to assist the unexpected breech, how to minimise haemorrhage and to have confidence-as-conviction to manage whatever presents. The notion of dread, foreseeing what might happen, was enabling for participants in this study. Dread drives preparation for emergencies, checking equipment, always safeguarding the women within the space of the primary unit.

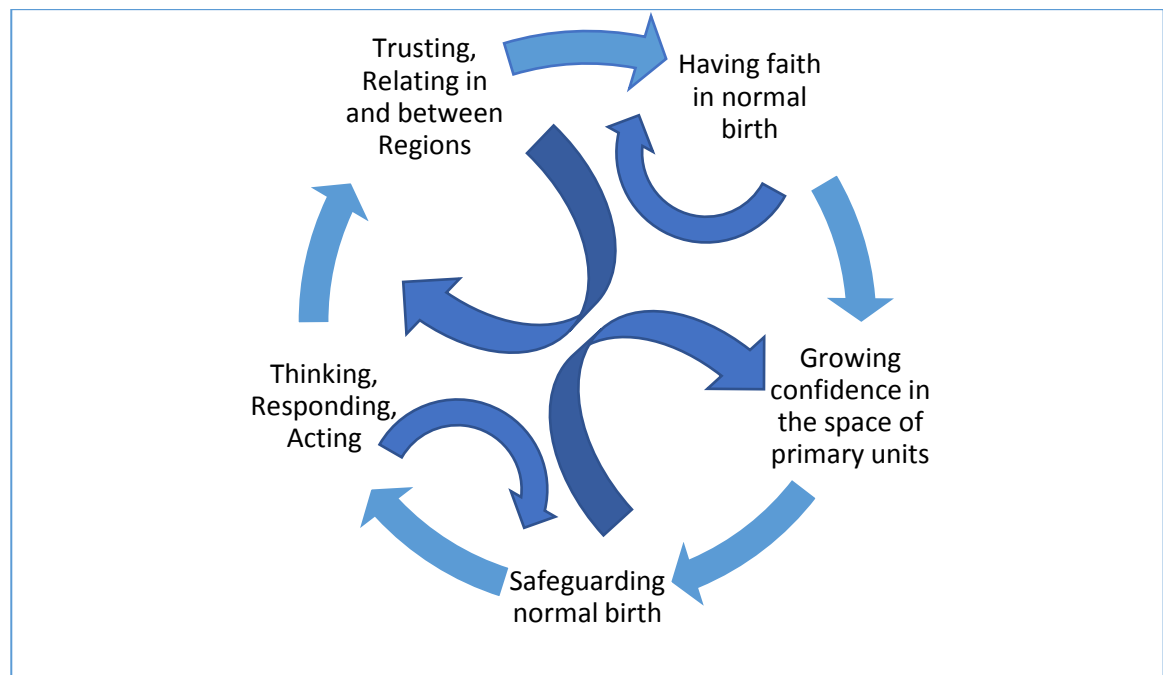
Supportive collegial relationships are also vital to sustaining midwives who provide labour care in primary units. Obstetricians who believe that primary units have a place in maternity care enhance the midwife's confidence to provide labour care. Obstetricians need to consult in the space of the primary unit; it is in this space that the distance, the community, the needs of women/families and midwives is revealed. Such things cannot be uncovered through telephone consultations, virtual referrals or consulting within the obstetric hospital clinics.

Colleagues who work in secondary/tertiary obstetric hospitals need to show respect and appreciation for midwives working in primary units. Midwifery, obstetric and ambulance personnel need to acknowledge that transfers from primary units are inevitable in a well-functioning maternity service.

Primary units are cost effective, safe and research evidence reveals that women incur fewer interventions when commencing labour in these units. Women, health professionals and communities need to retain faith in the safety of these units. The midwives who provide labour care in this space are constantly balancing the 'normal' and 'not normal'; it is confidence-as-conviction that enables, safeguards and sustains practice in primary units.

The diagram that follows (Figure 1) shows the interwoven nature of enabling, safeguarding and sustaining; what ‘works’ for midwives to provide labour care in primary units. Confidence-as conviction describes the coalescence of these notions.

### **Providing labour care in Midwife-Led Primary units: Confidence-As-Conviction**



**Figure 1:**

### **Gaining of Confidence**

This study highlights the importance of midwives having a mode of confidence to practise within a primary unit, distanced from obstetric/neonatal doctors and technological support. The participants in this study have faith and confidence to provide labour care in this space. Midwives willingly assist colleagues who are new to working in primary units or uncomfortable with labour care in primary units; they offer support, guidance and reassurance.

Midwives are drawn in to working in a primary unit through varying ways: such as their faith in the primary unit or being encouraged by a midwife mentor/manager. At times, it is the woman who decides that the primary unit is the place for labour and the midwife follows the woman’s choice. Midwives in this study describe their initiation to normal birth through experiences including a ‘baptism of fire’ and by working in a community

that builds confidence and belief in normal labour and birth. Alternatively, some midwives were drawn into primary units through happenstance such as moving to that community region, while others described the importance of their student experience when they spent time in a primary unit and/or experienced strong mentoring toward protecting normal birth. The welcoming from like-minded colleagues draws midwives into what becomes a long-term commitment to primary unit care.

### **Supporting Each Other**

Something significant ‘happens’ for midwives through working in primary units and being alongside colleagues in a neighbourly way. Their confidence grows, their experience in normal birth builds and is shared. It is the ‘how’ of working that creates enjoyment, liking, or even love for primary unit midwifery. They have learnt that colleagues are there to support, encourage, to show, to guide and to help. The space of the primary unit region is ‘felt’ space; it has an ambience that promotes normal birth, there is time for normal birth to unfold. Seeing good outcomes reinforces the normal; the midwife is rewarded by the beauty of the waiata (song), the water-birth of the first-time mother. When the midwife is trusting in the process of birth, this instils confidence in the woman and her supporters. Distance just ‘is’ and, therefore, is managed in the way of working in this space.

Bollnow (1961) stated that distance depends on how a person is feeling at that moment. Midwives who hold an ingrained belief, faith and hope in normal birth view the primary unit region as the right space for low-risk women. There is a trusting, believing and relying on a confidence that most low-risk women will labour and birth well. This belief and faith expands when normal outcomes unfold and, in turn, the midwife’s confidence flourishes. Participants know the evidence and quote research that low-risk women have less caesareans by commencing labour in a primary unit. They appear wedded to ‘their’ primary unit and speak of loss if further closures of primary units occur. Although the participants were from various primary units, a sense of camaraderie for those providing care in primary units prevails.

### **Pointing Toward Something**

When necessary, there is a pointing towards something, the possibility of a problem during labour. Perhaps it is nothing important, as yet. Midwives in primary units are

always assessing: 'is it normal' or 'is it not normal'? Unsafeness can lurk in the darkness; concealed, not yet revealed (Heidegger, 1996; Smythe, 1998). Midwives need to be watching, knowing that the normal and not-normal can co-exist. The midwife providing labour care in the primary unit region is thinking, anticipating, watching and waiting for the revealing. Other problems show themselves in the light, but still need to be recognised and acted upon. The woman's labour that is too slow signals concern. The experienced mother who feels something is not right with this labour needs her concern taken seriously. Lack of progress in second stage is a concern. The baby who has serious decelerations is an urgent concern. These situations cannot be overlooked, cannot be ignored and cannot be dealt with by 'crossing your fingers' in hope that the problem will disappear. Yet, from time to time, there is a lingering sense of one's 'fingers crossed' until the baby is safely born. These midwives hold the paradox of both embodying confidence in normal birth while being mindful of expecting the unexpected.

### **Keeping a Watchful Eye**

Midwifery colleagues working in the primary unit share concern for women labouring in the unit. They keep a watchful eye on what is happening. They speak up with courage when they 'see' something is not right or when something might become a problem. Smythe (1998) showed how the "concernful spirit of practice helps make 'being safe' possible while the unconcerned spirit simply lets the situation 'be'" (p. 225). The concerned 'other' midwife is acting as guardian for the LMC or midwife who might not be noticing what a colleague 'sees' or anticipates. At times, one might be too close to 'see' that the labour is going on for too long. The opportunity to seek help needs to be seized. Making the call requires a happening of decisions in a timely manner. Decisions are not always well-defined. Midwives in the primary unit draw on their thinking, their analysis of what is happening. Thinking alongside one's practice wisdom, safeguards. Participant Lynn described a woman in labour who felt something was not right; Lynn did not wait for the woman to have an hour of pushing in second stage. She transferred early knowing that further expertise was needed. The midwife is attuned to the call to act 'now'. There is a readiness which safeguards.

### **Managing the Unexpected**

Midwives work with 'thrownness' in primary units. One is not aware of mood or attunement until things change unexpectedly and one is thrown into a difficult labour, a

surprise breech presentation, resuscitating a baby, postpartum haemorrhage or managing the 'now'. In these moments, the midwife is acutely aware of trusting self and others. The midwives in primary units reiterated doing the best they can do during challenging or emergency situations. There is hope for good outcomes; midwives 'touch wood' superstitiously for good luck. The notion of dread is experienced as a possibility of things going wrong, while fear is something real, something that can be named; the fear for the baby's outcome when showing significant fetal distress. There is an undercurrent of dread (King, 1964) of not doing one's very best or not performing perfectly, balanced with confidence that everyone will pull together during an emergency and do the best they can. Midwives know the possibilities of harm to the mother and baby; even to the point of death. It seems that the combination of having experienced fear, which leaves a legacy of dread, drives midwives to keep rehearsing, preparing, undertaking emergency courses and practising their skills for the inevitable future time that such skills are called to hand. Such pre-work builds the confidence which keeps dread as an enabling mood. It is there to prompt action rather than to undermine commitment to primary units.

The findings of this study support research by Calvert, Smythe and McKenzie-Green (2017) which reported that midwives are constantly working to be ready for practising safely in their practice context. Midwives in primary units find ways to keep their hands practised. There is a readiness to undertake timely referrals. In this study, the resounding confidence in the team in the primary unit is apparent. There is conscious knowing that colleagues will 'lend a hand', provide a 'helping hand' and it is 'all hands to the deck' during emergency situations. No one hides or shies away from answering the call of the emergency bell. The 'thundering herd of elephants' appears in emergencies; everyone in the unit responds in whatever way they can to be of help. Being prepared to handle anything with a readiness to work together enables, safeguards and sustains labour care in primary units.

### **Supporting Labour Care in Primary Units**

It matters that obstetricians, steeped in medical/obstetric practice at the secondary/tertiary hospital region, support the space which enables and safeguards normal birth. Some obstetricians play a significant role in supporting and sustaining their midwifery colleagues to provide labour care to women in primary units. Their consulting

processes are crucial in measuring the 'level of concern' regarding potential complications.

The obstetrician holds responsibility for complex decision-making. Some complications clearly call for the woman to labour within the secondary/tertiary hospital region. However, for other women, the obstetrician and midwife formulate an individual plan. The obstetrician can triage the woman back to the primary unit. In these cases, the obstetrician is carrying the load of responsibility for women who are not 'low-risk' but are deemed safe to commence labour in the primary unit. Yvonne (obstetrician) explained that she provides 'back-cover' for midwives providing of labour care in the primary unit. When there is known 'risk', the load is lightened by the obstetrician sharing responsibility with the midwife in the primary unit region.

It became apparent that obstetricians accept that some women would not present in labour at the secondary/tertiary region for a variety of reasons. For these women, it is reasoned to be safer for them to labour in a primary unit, with a known LMC. Pragmatism and common sense prevail. Midwives follow a designated plan for intrapartum care seeking to provide additional safeguarding. When a woman has a history of postpartum haemorrhage, the obstetrician is assured by the midwife's ability to insert an intravenous line and administer uterotonics.

In this study, obstetricians showed admiration for the way that midwives manage events in the space of primary units. There was praise for the midwife's ability to manage the abnormal, for instance, the unexpected breech birth. The notion of neighbourliness is reinforced with obstetricians reiterating to the obstetric team that the primary unit is like a family. They are calmed by knowing that experienced midwives support those with less experience. They feel confident that experienced midwives constantly safeguard labour in primary units. The midwife managers know what is happening in 'their' unit. Midwifery colleagues speak up unafraid to address concerns. Transgressions of practice are addressed and followed through to ensure learnings occur. Giving feedback to one another in a respectful, yet constructive way, ensures ongoing safeguarding and sustaining.



## **Sustaining Labour Care in Primary Units**

Inter-relating, connecting and valuing one another is sustaining. There are times when communication lapses between practitioners from different regions; differing values and beliefs related to labour and birthplace collide. The functioning of the primary region is dependent upon an effective ambulance service and the secondary/tertiary region to manage complications after transfer. It is possible that belief in normal is not held to the same extent by those in the secondary/tertiary region which exists for managing complications; its function is not that of holding and protecting normal birth.

The findings of this research show that on many occasions, excellent collegial conversations are in play; the interface and interconnecting of midwife to midwife and obstetrician to midwife across regions is often exemplary. Obstetricians who consult in primary units appear to establish close knit relationships with midwives enhancing respectful conversation. The person who undertakes phone conversations with a mind-set toward collegial dialogue is unlikely to be abrupt. The person who answers the phone to accept a transfer needs to have time to listen to their colleague in the primary unit. Obstetric doctors and midwives sometimes combine for emergency training in primary units. This appears to benefit team work and promotes an understanding of the realities of working at a distance in a primary unit.

Regardless of one's personal belief, the interface of relationships needs to be that of working together. Different 'mind-sets' are in play with regard to place of birth. Pre-understandings and prejudices influence one's interpretations and judgement. Philosophical beliefs are shaped by one's past and the world of practice. The midwife in the primary unit holds the belief that a low-risk woman will labour best in the space of a primary unit. The midwife and obstetrician at the secondary/tertiary region might not hold this belief because they deal with transfers and complications. They may only see labours in which significant problems have arisen. Togetherness means understanding enough of the situation of 'other' to be accommodating to their needs.

## **Preserving Normal Birth**

The space of the primary maternity unit is that of protecting and preserving normal birth. Heidegger (1996) said that dwelling itself is always staying with things; it is a preserving. There needs to be nurturing, protecting, and cultivating of the things that entail labour

care in primary units. Normal labour and birth is something vulnerable and precious. Midwives are the 'keepers of normal'; primary units provide the space for normal labour care, normal birth.

Not all midwives feel comfortable providing intrapartum care in a primary unit; such discomfort is akin to feeling fearful in that space. Bollnow (1961) described fear as being the constriction of one's heart when the outer world draws in oppressively as opposed to when fear departs, the world spreads out enabling a freer space for action. Midwives in this study revealed a mode of confidence-as-conviction enabling them to keep their mindfulness of fear and dread at bay. Overriding their practice is an unwavering belief and faith in normal birth. They want to practise freely and with confidence in the space afforded by the primary unit region.

### **Comparing Findings with Literature**

This study is believed to be original in describing the intertwining of what enables, safeguards and sustains midwives to provide labour care in primary units, what 'works'. Confidence arose as an important finding in this study and is echoed by others. Bedwell et al. (2015) noted that confidence is bolstered in a familiar environment, however, there is fragility in confidence; conflict during telephone consultation and/or face-to-face handover of care diminished the midwives' confidence. Midwives valued their practice experience, particularly the amount of hands-on experience in intrapartum care (Bäck, Hildingsson, Sjöqvist, & Karlström, 2017). Midwives who worked in rural areas believed that practising 'normal' birth strengthened their midwifery knowledge (Toohill, Sidebotham, Gamble, Fenwick, & Creedy, 2017). Similarly, midwives who worked with normal birth adapted more readily to facilitating water births; this was viewed as just another addition to assisting 'normal' birth (Nicholls, Hauck, Bayes, & Butt, 2016). The concept of respectful communication was paramount to fostering and sustaining midwives' confidence in midwife-led units (Bailey, 2017; Crowther, 2017; Watson, Heatley, Gallois, & Kruske, 2016).

Differences of opinions regarding the safety of midwife-led units was reported by Henshall, Taylor and Kenyon (2016). A chasm exists with marked difference of opinion between midwives; some midwives do not offer women the option of a midwife-led unit

as place of birth. Although the findings from my study affirm belief in primary units, it is apparent that this belief is not universally held by all maternity practitioners (Kennedy, Grant, Walton, Shaw-Battista, & Sandall, 2010). The findings from my study, stress the importance of obstetricians conducting their clinics on site in primary units so that they become acquainted with the context of the region and develop supportive relationships with the midwives working in these units.

Further to outcomes in my study, Bailey (2017) reported the following findings from 47,381 women with low-risk pregnancies in South Auckland, New Zealand. Labour in free-standing birth centres was associated with significantly lower maternal intervention than labour in the obstetric unit and was not associated with increased perinatal morbidity. Transfer rates were similar to the Birthplace in England study with increased prevalence for women greater than 35 years of age and those having a first baby. Bailey argued that women of advanced maternal age (> 35 years) and women having a first baby not be excluded from primary units because of increased transfer rates. Most women having these 'risk' factors had favourable outcomes (whether transferred or not). Bailey concluded that routine obstetric unit birth is not necessarily safer for low-risk pregnancies and with appropriate screening, it is likely that a large proportion of women birthing in obstetric units could safely birth in primary units.

In a similar manner, Christensen and Overgaard (2017) reported that freestanding midwifery units in North Denmark had significant advantages for women regardless of parity and the authors supported low-risk women using these units to possibly reduce caesarean birth rates. Based on the findings of local and international birthplace studies, it is possible that the 'normal birth' rate of 33% in Aotearoa-New Zealand (Ministry of Health, 2015) may increase if a greater number of healthy low-risk women commenced labour in a primary unit attended by 'confident' midwives. Normal birth has multiple benefits (as stated in Chapter one) including promotion of early breastfeeding and the physical and emotional wellbeing of women and babies (Ministry of Health, 2015).

Shaw et al. (2016) noted that a resurgence in midwife-led care and low-risk women giving birth in birth centres (or home) could turn the tide of intervention-orientated birthing. These authors argued that over-intervention in high-income countries has led to harms such as placenta accreta from previous caesarean as well as spiralling costs. They concluded that progress requires the ability to normalise birth for most women and

mitigate fear for women and providers. Poor relationships and lack of respectful communication were noted as contributing to sentinel events. Shaw et al. pointed to midwives providing care in freestanding birth centres (or home) as a means of optimising birth for low-risk women (Shaw et al., 2016).

Many years ago, Dick-Read (1954) proposed that the practitioner's communication and manner toward a pregnant woman could either impart confidence or awaken fear. Fear of childbirth denies hope and faith; reliance on technology erodes the midwife's skills (Kitzinger, 2005). De Vries (2012) described midwifery, obstetrics, fear and trust as voices in harmony when good maternity care is provided. In situations where fear dominates trust and obstetrics dominates midwifery, poor health outcomes occur with increased interventions, increased costs and less satisfaction. De Vries challenged practitioners to trust a woman's body to give birth, stating: "fear keeps us on guard [while] trust promotes cooperation and drives out unhealthy fear" (p. 10). In my study, the mode of a midwife being-confident in providing labour care in the primary unit is a confidence which overrides such fear.

The purpose of a hermeneutic phenomenological study is to reveal what we already know but have taken-for-granted and often overlooked. My study gathers together the insights from wide ranging literature to shed light on the taken-for-granted things of what 'works' for midwives providing labour care in primary units. While confidence arises in the literature, the balancing of an appropriate confidence termed confidence-as-conviction by midwives providing labour care in primary units is an original finding from this study.

### **Recommendations for Practice**

Primary units need to be recognised for holding and protecting normal birth. The space of primary units is primarily the domain of midwives; midwives need faith in these units to portray primary units as a safe option for low-risk women. All midwives need be willing to share research evidence with women/families (and colleagues) that primary units are appropriate for low-risk women. In cases where a woman has some risk, the level of 'risk' is aptly assessed by an experienced obstetrician who consults within the context of the primary unit.

LMC midwives, core midwives, managers and obstetricians need to disseminate their practice of how they enable, safeguard and sustain midwives to provide labour care in this context. Midwife managers need to be managing what happens in the unit. All midwives need to 'keep an eye out' for each other to safeguard women and the reputation of primary units. There needs to be support and guidance for midwives feeling uncomfortable with labour care in primary units until confidence is gained. Experienced primary unit midwives need to be employed to assist with mentoring and/or working alongside midwives new to primary unit practice. While a scheme of 'supporting' might incur cost, there are informal processes in existence that could be formalised. The cost-benefit of mentoring midwives to provide labour care in primary units is likely to outweigh the cost of further overloading secondary/tertiary hospitals with low-risk women. In addition, there are significant costs associated with interventions when low-risk women commence labour in a secondary/tertiary hospital. These women are at increased risk of undergoing a preventable caesarean birth (had labour been managed differently) which is costly in manifold ways.

Primary units need ongoing funding to remain viable and to attract women to labour in that setting. Health boards (and Trusts) need to give priority to primary units and acknowledge their importance for the community, including Māori women who are currently the highest users by ethnicity. The regions of the secondary/tertiary hospital and ambulance service are essential to sustaining primary units. To this end, ambulance services and transfers need to be efficient in terms of timeliness and availability of paramedic support. The secondary/tertiary hospital must be staffed adequately to welcome and triage transfers promptly. Overarching these practicalities, there needs to be an ambience of goodwill, respect and understanding of the context for each practitioner.

Is there benefit in a gathering of minds between midwives at the primary unit region with midwives and doctors from the secondary/tertiary region? How could 'middle-ground' be founded where doctors and midwives have confidence in low-risk women commencing labour in the primary region? Transfers in to secondary/tertiary care need to be accepted as inevitable for a proportion of women. Midwives in primary maternity units cannot provide intrapartum care without access to the secondary/tertiary region service when indicated. The question that one ponders is: Do 'they' who work in the

obstetric region only (doctors and secondary/tertiary midwives) believe in the functioning and role of the primary maternity unit region?

Good relationships between practitioners within and across regions matter to the work of midwives providing labour care in primary units. When there is understanding and acknowledging of the context, the midwife is affirmed and sustained in continuing to protect 'normal' birth in primary units. Praise that affirms the work of midwives or commends their exceptional emergency skills makes a difference, reinforces confidence and encourages them to keep practising in this setting.

### **Recommendations for Education**

Education is a means of promoting further thinking and learning. Student midwives potentially gain a different perspective in seeing the unfolding of normal labour in the context of a primary unit. However, there are too few primary maternity placements, too few LMC midwives providing labour care in these units and too few women commencing labour in this setting when compared with the current number of student midwives in Aotearoa-New Zealand. How can student midwives be educated in a primary unit context? Some midwifery schools have established virtual birthing rooms where the space/place is a standalone midwife-led unit. Alternatively, students might benefit from hearing narratives about enabling, safeguarding and sustaining labour care; what 'works' in primary units. Narratives that show the simplicity of providing labour care while paradoxically showing the complexity in anticipating complications would enhance learning for student midwives, paramedics and obstetric doctors.

LMC midwives might need further education and guidance in booking women for labour in primary units, including developing appropriate plans for women with minor risk factors. There are advantages for combining some ongoing education for obstetric doctors and midwives; team-based simulation for obstetric emergencies enhances safety. Multi-disciplinary education is available for emergency training and this proves beneficial when held in the setting of primary units. Midwives in primary units need to be confident in breech birth, neonatal resuscitation and 'expecting the unexpected'.

Extending education to explore beliefs, fear and research-evidence in relation to birthplace is imperative to promoting usage of primary units. So too, is offering practical

support to midwives providing labour care in primary units. Stone (2012) described the socialisation and integration into the culture of the profession as of equal importance to theoretical and practical knowledge. Stone further suggested that the setting where the student midwife works is as influential as the process of learning competencies for practice and will remain with the midwife upon qualifying.

### **Recommendations for Future Research**

Hearing the voices of those who provide care in other freestanding midwife-led units nationally and internationally would be beneficial. Midwife-led units are a particular space for holding normal birth; yet, there is sparse literature about how midwives are enabled, safeguarded and sustained to provide intrapartum care, what 'works'. The meanings of each of these terms are open to many interpretations and additional research may reveal valuable insights.

Further research is needed to hear about the experience of women and families in relation to influences of using and/or not using a primary unit for labour care within Aotearoa-New Zealand. In the study of how women in Canterbury decided on place of birth, Monk et al. (2014) acknowledged the limitations caused by the major earthquake in the region that restricted options with maternity facilities. Within Aotearoa-New Zealand, as with places in the United Kingdom, transfers can be thwarted by weather and lack of access. Additional research regarding transfers from the perspectives of all personnel is warranted to inform quality processes. The time taken for transfers and outcomes for women and babies could be explored further in different regions.

How labour care is provided in primary units that are a considerable distance (greater than 60 minutes) from a secondary/tertiary hospital needs researching. Rayment et al. (2015) suggested review of multi-disciplinary guidelines to ensure the fit with practice in midwife-led units, allowing for flexibility of women's choice. There is a need to capture further qualitative data about what enables primary units to remain in existence.

The question of why some midwives choose not to work in primary units, or why LMC midwives do not book women at a primary unit also needs exploring to uncover assumptions about perceived barriers. Further research directed at the aftermath of when

mortality / morbidity occur in a primary unit might shed light on why these units are under-utilised by women and midwives.

### **Strengths and Limitations of this Study**

Strengths of this study include the congruence between the research question, methodology and methods. Participants included midwives and obstetricians who worked in primary units, therefore different perspectives were gathered. The process of data collection and analysis occurred over a lengthy period ensuring that understandings were developed in a dwelling-with-and-between manner. This study is limited to the experience of 14 participants who work within primary units in the greater Auckland region.

My findings revealed that the notion of dread enabled midwives to be prepared for the unexpected and leap ahead or leap in with concerned-care. This finding could be limited to participants in this study. There may be other midwife-led units in which midwives do not have an attunement of dread that helps keeps them confident. I was a member of the Midwifery Council of New Zealand during the time of data collection. It would have placed both myself and the participant in a difficult situation had I heard stories of deficits in care. Thus, I stayed focused on the positive stories about 'what works'. This does not mean that the less positive stories do not exist. In keeping with hermeneutic phenomenology, there is no claim of transferring findings. The interpretations belong to the researcher. While steps have been taken to ensure rigour, the interpretations are within the fusion of horizons; those of the researcher and participants at this point in time. Hermeneutic phenomenology seeks to richly describe and more fully understand phenomena relating to the research question. In doing so, the thinking provoked emergence of further questions, further thinking and the need for further research.

### **Concluding Thinking**

Aristotle's thinking was that the brave man [sic] is between the two poles of confidence and fear (Rotenstreich, 1972). Midwives need a distinct mode of confidence to practise in the primary unit; keeping faith in normal labour, being confident in this setting and using their practice-wisdom. At the same time, midwives need to expect the unexpected, leap ahead or leap in to safeguard and act promptly when things deviate from normal; occasionally, they are required to act in the moment such as assisting a breech baby. The



midwives' work is in relative isolation away from doctors and technological facilities. The 'team' of midwives in the primary unit gather strength in trusting one another. The obstetrician is part of the team when he/she consults on site and develops relational understanding of what works for the primary unit, the midwives and community. Midwives in primary units keep an eye out for each other and managers know what is happening in 'their' unit; midwives speak out when required and are unafraid. Every midwife in the primary unit needs to have a vested interest in protecting normal birth while ensuring the woman and baby's wellbeing is never compromised. Midwives in primary units are tasked with constantly thinking ahead, not to discourage the unfolding of normal, but to shed light on the things that might become problematic. The responsibility of providing labour care in a primary unit does not rest with one midwife alone.

In concluding the spiralling circular nature of this study, I return to the beginning and the research question - What works for midwives to provide labour care in primary units? What works is that which is beyond a superficial focus on skills and procedures. It is the nature and quality of the confidence embedded in the midwife. It is possible that a particular mode of confidence is the overriding attribute that midwives need to develop in order to work in primary units. Such confidence derives from the midwife believing that the nature of practice in midwife-led units makes the units safe for labouring women. Furthermore, the midwife believes that primary units are the best place/space for low-risk women to commence labour. The midwife has to retain faith in the unfolding of normal labour while paradoxically keeping alert to the dynamic changing nature of childbirth. The midwife needs to trust her own skills. In addition, she needs to trust the whole team to work together when called upon. The ambulance service and obstetric hospital region need to demonstrate exemplary support for midwives working without obstetric/neonatal backup on site. The reward of seeing normal labour and birth in a midwifery-led unit grows and maintains trust and confidence. Perhaps such confidence can only grow in the space of a stand-alone midwife-led primary unit where the 'normal' prevails. Working with abnormal labour and emergencies in a secondary/tertiary obstetric unit is unlikely to cultivate the confidence required for a midwife to work in a primary unit. Trusting and not-trusting are always in play; **confidence-as-conviction** is what works for midwives to provide labour care in primary units.

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## Appendices

### Appendix A: Ethical Approval



A U T E C  
S E C R E T A R I A T

19 November 2014

LizSmythe

Faculty of Health and Environmental Sciences

Dear Liz

Ethics Application: **14/364 What enables safeguards and sustains midwives to provide labour care in primary maternity units in Aotearoa/New Zealand.**

Thank you for submitting your application for ethical review. I am pleased to confirm that the Auckland University of Technology Ethics Committee (AUTC) has approved your ethics application for three years until 17 November 2017.

AUTC suggests sending participants a copy of their story for their approval and advise participants of this in the Information Sheet and remove the word 'likely' in the section on costs.

As part of the ethics approval process, you are required to submit the following to AUTC:

- A brief annual progress report using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 17 November 2017;
- A brief report on the status of the project using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>. This report is to be submitted either when the approval expires on 17 November 2017 or on completion of the project;

It is a condition of approval that AUTC is notified of any adverse events or if the research does not commence. AUTC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, we ask that you use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz).

All the very best with your research,

Kate O'Connor  
Executive Secretary  
**Auckland University of Technology Ethics Committee**

Cc: Marion Hunter

# Participant Information Sheet



**Date Information Sheet Produced:**

29/10/2014

**Project Title**

What enables safeguards and sustains midwives to provide labour care to women within primary maternity units in Aotearoa / New Zealand.

**An Invitation**

My name is Marion Hunter and I work as a midwifery lecturer at AUT. I am undertaking this study as part of my Doctor of Health Science through AUT. I invite you to be part of the research study as you enable women to commence labour in primary units. Participation in this study is voluntary and participants may withdraw from the study up until two months after their interview. After this time, participant's data will be merged with other data of similar themes.

I am completing my final appointed time on the Midwifery Council and members of Council sometimes view complaints from HDC and ACC. To prevent any conflict of interest, I request that if you are currently under a HDC process or a complaint through ACC, please do not volunteer for this study. There are a number of criteria that allow people to be part of this project. My research is focussed on positive narratives that enable, safeguard and sustain midwives to provide labour care to women in primary maternity units. I am placing an emphasis on positive outcomes and do not wish to dwell on negative clinical experiences for yourself or your colleagues.

**What is the purpose of this research?**

The purpose of this study is to ascertain what enables safeguards and sustains midwives to provide labour care to women in primary maternity units. This study will reveal the factors that enable midwives to provide safe care to women in primary maternity units in Aotearoa / NZ and what sustains these midwives to continue to practise. I will publish journal articles from this study, present at midwifery conferences and complete my Doctor of Health Science through AUT.

**How was I identified and why am I being invited to participate in this research?**

You will have received this invitation through contact from the Charge Midwife of the primary birthing unit where you provide care. You are eligible to participate if you meet the criteria below:

Inclusion criteria: You speak fluent English.

Exclusion criteria: You are currently under a HDC or ACC process of investigation.

**What will happen in this research?**

The study involves consenting to a tape-recorded interview with the researcher. Interviews might be as short as 20-30 minutes or up to 60 minutes depending on each participant. The participant can ask the tape recording to be stopped at any time during the interview. The data will be used for inclusion in my thesis and any publications or presentations arising from this.

### **What are the discomforts and risks?**

There is unlikely to be any discomfort or risk from being involved in the interview for my study.

### **How will these discomforts and risks be alleviated?**

You will not be identified in this research. You can choose a pseudonym (name you wish to be used in the study) and any identifying information about you or your place of work will be removed. There will be no identifying information in the thesis. Any data within presentations or publications from this study will be referenced to pseudonyms only. If information is provided about participants it will be in relation to the number of participants interviewed. No personal information will be disclosed.

Confidentiality is very important and you can be assured that I will not reveal that you participated in my study. You are free to self-identify but I cannot reveal details of any participants. My primary supervisor will retain the consent forms in a locked cupboard at AUT South. Transcripts from the interviews will be stored on my computer and will be password protected. The transcripts will remain stored in this file for up to six years as per AUTC requirements.

If in the process of interview you disclose a story that causes you discomfort or distress and you feel that you need to talk through this issue with another person, then there is the opportunity for you to have counselling through AUT counselling services. You will need to contact the centre in person, or by phone:

09 921 9992 for City campus (WB219) and South Campus (MB reception)

or 09 921 9998 North Shore Campus (AS104) to make an appointment.

- You will need to let the receptionist know that you are a research participant.
- You will need to provide your contact details to confirm this.
- You can find out more information about the counsellors on the website: [http://www.aut.ac.nz/students/student\\_services/health\\_counselling\\_and\\_wellbeing](http://www.aut.ac.nz/students/student_services/health_counselling_and_wellbeing)

### **What are the benefits?**

Completing this research will allow me as a student to complete my Doctor of Health Science qualification. I wish to present findings from this study to enhance knowledge about the factors that safeguard and sustain midwives who provide labour care in primary maternity units in Aotearoa / New Zealand. It is likely that participants might benefit from reflecting on narratives that enable and safeguard care in primary maternity units.

### **How will my privacy be protected?**

Your privacy will be protected through a number of ways. A private venue will be offered for the conduct of the interview. Only your pseudonym will be used in the study. Consent forms with your actual name will be locked away at AUT. I will adhere to confidentiality about research participants at all times, including not revealing any detail suggesting who participants might be.

### **What are the costs of participating in this research?**

The cost of participation is likely to be the cost of your time.

### **What opportunity do I have to consider this invitation?**

If you would like to participate, I would appreciate you contacting me within 10 days of receiving the invitation. If I don't hear from you, I will assume that you would prefer not to participate in my study.

**How do I agree to participate in this research?**

If you wish to participate in this study, please contact me through the following ways:

Email- [mhunter@aut.ac.nz](mailto:mhunter@aut.ac.nz) Mobile phone or text: 021 225 3229

Once contact is established, I will offer to answer any questions about the study and ask you to sign the consent form prior to undertaking an interview.

**Will I receive feedback on the results of this research?**

Yes, you will be offered a summary of findings of the study. I will write a journal article and send you a copy of the article once it is published.

**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, Dr Liz Smythe [lsmythe@aut.ac.nz](mailto:lsmythe@aut.ac.nz) Phone: 021 351 005

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTC, Kate O'Connor, [ethics@aut.ac.nz](mailto:ethics@aut.ac.nz) , 921 9999 ext 6038.

**Whom do I contact for further information about this research?**

***Researcher Contact Details:***

Marion Hunter: [mhunter@aut.ac.nz](mailto:mhunter@aut.ac.nz) or Mobile: 021 225 3229

***Project Supervisor Contact Details:***

Dr Liz Smythe [lsmythe@aut.ac.nz](mailto:lsmythe@aut.ac.nz) or mobile 021 351 005

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*,  
AUTC Reference number *type the reference number*.

# Consent Form

For use when interviews are involved.



*Project title: What enables safeguards and sustain midwives who provide labour care in primary maternity units in Aotearoa / New Zealand.*

*Project Supervisor: Doctor Liz Smythe*

*Researcher: Marion Hunter*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated 29/10/14.
- ☐ 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 I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- ☐ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a copy of the report from the research (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 19 November 2014 AUTEK Reference number 14/364**

*Note: The Participant should retain a copy of this form.*

## **Appendix D: Prompt Questions for Interview**

### ***Prompts for Interviewing***

*Please tell me how you came to work in a primary unit*

*Tell me about a woman that you recently encouraged to labour in the primary unit ..and another...a time you felt proud....*

*Can you think of a time that you helped a midwife...*

*Can you tell me about a time where there maybe were some challenges?*

*How do you know whether things are going well?*

*What works to keep practising?*

Alongside these prompt questions were a list of further prompts such as:

*Can you give me an example of that please?*

*Do you recall a particular time of this happening?*

*What happened next?*



## Appendix E: Transcriber Confidentiality Agreement

# Confidentiality Agreement



*For someone transcribing data, e.g. audio-tapes of interviews.*

*Project title: What enables, safeguards and sustains midwives who provide labour care in primary maternity units in Aotearoa / New Zealand.*

*Project Supervisor: Dr Liz Smythe*

*Researcher: Marion Hunter*

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- ☒ I understand that all the material I will be asked to transcribe is confidential.
- ☒ I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- ☒ I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....Shoba Nayar.....

Transcriber's Contact Details (if appropriate):

Email: snayar19@gmail.com.....

.....

.....

.....

Date: 18<sup>th</sup> April 2015

Project Supervisor's Contact Details (if appropriate):

.....Dr Liz Smythe lsmythe@aut.ac.nz.....

**Approved by the Auckland University of Technology Ethics Committee on *type the date on which the final approval was granted* AUTEK Reference number *type the AUTEK reference number***

*Note: The Transcriber should retain a copy of this form.*

