MIDWIFERY PRACTICE DURING BIRTH: RITES OF PASSAGE AND RITES OF PROTECTION

Rachel Reed RM BSc(Hons)

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School of Nursing and Midwifery
Faculty of Science, Health, Education and Engineering
University of the Sunshine Coast
Sippy Downs Drive, Sippy Downs, Queensland 4556
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Abstract

This study explored midwifery practice during birth. In particular, the experiences, actions and interactions between midwives and women during uncomplicated, normal births.

Most of the existing literature focuses on outcomes associated with individual practices; and there is a lack of research evidence supporting many of the common midwifery practices carried out during birth. There is also limited research exploring midwives’ experiences and perceptions of their practice during birth; although it seems that the context of midwifery practice, and cultural norms influence practice. Studies exploring women's experience of birth have identified an altered state of consciousness, and issues of control as key factors. However, there has been very little research specifically examining women's experience of midwifery practice during birth. This study sought to explore the experience of midwifery practice from both the perspective of the midwife and the woman.

The study is a narrative inquiry, and a feminist approach was taken throughout the research process. Birth stories were gathered from mothers and midwives during in-depth interviews. The participants had either experienced or attended an uncomplicated vaginal birth, and were encouraged to share their story of this experience. Narratives were created from the interview transcripts and analysed to identify common themes. An explanatory framework ‘rites of passage’ was then applied to further illuminate the narrative of midwifery practice during birth.

The findings are presented in three chapters. The first focuses on the mothers’ experiences of birth as a rite of passage. This chapter provides the foundation for the following chapters that present midwifery practice during birth. Midwives enacted ‘rites of passage’ during birth that tended the boundaries of aloneness, and nurtured self-trust and inner wisdom. Midwives also enacted ‘rites of protection’ which contradicted rites of passage, but tended the needs of the institution. Tensions arose between these two types of rites, and conflicting cultural values were transmitted and reflected through their performance.
Findings are discussed in relation to the literature, and the thesis concludes with recommendations for midwifery practice, midwifery education, and further research. Recommendations centre on a model of midwifery practice as 'ritual companionship' as the basis for developing midwifery practices that are aligned with women's experience of birth.
Publications and presentations resulting from this thesis

Journal – peer reviewed

Journal – non-peer reviewed

Conference – peer reviewed

Conference – invited speaker
Statement of Original Authorship

The work contained in this thesis has not been previously submitted to meet requirements for an award at this or any other higher education institution. To the best of my knowledge and belief, the thesis contains no material previously published or written by another person except where due reference is made.

Signature: 

Date: 19th July 2013
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Glossary of Midwifery Terms
(as utilised in this thesis)

Amniotiomy (ARM): surgical rupture of the amniotic sac, usually using an amnihoook. This procedure is commonly undertaken to induce or accelerate labour.

Augmentation: Acceleration of labour once it has commenced. It involves carrying out an amniotomy and/or an intravenous syntocinon infusion.

Caesarean: the surgical delivery of a baby via the mother’s abdomen. Also referred to as a c-section, caesarean section and caesar.

Cardiotocograph (CTG): a machine used for monitoring the fetal heart rate and maternal contractions. It provides a graphic representation of the correlation between fetal heart rate patterns and uterine contractions in labour.

Cephalic replacement: an extremely rare procedure used in cases of shoulder dystocia when a vaginal delivery fails. The baby’s head is flexed and reinserted into the vagina allowing a caesarean to be performed.

Chorioamnionitis: inflammation of the fetal membranes (amnion and chorion) caused by infection.

Continuous electronic monitoring: the use of a cardiotocograph machine continuously throughout labour.

Controlled cord traction: a method used to deliver the placenta following birth. It is usually performed following the use of an oxytocic medication. The placenta is pulled out using the umbilical cord to apply traction.

Doppler: a hand held device that is used to listen to the fetal heart rate through the maternal abdomen. Ultrasound technology is used to identify motion in the fetal heart which is then converted into sound.

Epidural analgesia: a form of anaesthetic or pain relief administered via an injection into the epidural space around the spinal cord.

Episiotomy: a surgical incision into the perineum during birth. It may be carried out to expediate birth, or to provide access for instruments. It can also be carried out in the mistaken belief that it can prevent tearing.

Fetal distress: the clinical manifestation of fetal hypoxia. It may be suspected in labour if the fetal heart rate is abnormal.

Fetal heart rate auscultation: listening to the fetal heart.

Forceps: instruments used to deliver a baby via the vagina. They are used if the baby is malpositioned, not descending, and/or there is suspected fetal distress.
Forewaters: the amniotic fluid contained in the part of the amniotic sac below the presenting part of the baby (usually the head). The forewaters assist with the dilation of the cervix and provide protection from compression for the baby during contractions.

Induction: the process of starting labour artificially.

Instrumental birth: the use of forceps or ventouse to assist with birth.

Intrapartum: labour.

Lithotomy: a position used during birth to allow practitioners access to the woman’s vagina. The woman lies on her back with her legs held up and out, secured onto the lithotomy poles by straps.

Liquor: the fluid around the baby contained in the amniotic sac.

Maternal observations: clinical assessments including blood pressure, pulse, temperature and contraction pattern.

Meconium liquor: when the baby has opened his/her bowels into the liquor. This occurs as the baby’s digestive system matures, or in cases of fetal distress.

Multiparous: a woman who has given birth more than once.

Nuchal cord: when the umbilical cord is around the baby's neck.

Operative delivery: the birth of a baby via caesarean or vaginally using instruments (forceps or ventouse).

Partogram: a graphical representation of the progress of labour. Practitioners document cervical dilatation and fetal descent onto the partogram. This document is used to inform decision-making regarding augmentation or an operative delivery.

Physiological placental birth: the birth of the placenta and membranes without any interference.

Primiparous: a woman who has given birth to one child.

Pinnard: an instrument shaped like a trumpet that can be applied to the maternal abdomen to hear the sounds of the fetal heart.

Pre-eclampsia: a complication of pregnancy involving three symptoms: raised blood pressure, proteinurea and generalised oedema.

Prophylactic oxytocic: an oxytocic medication given following the birth of the baby to augment the birth of the placenta during an actively managed placental birth.

Pudendal block: local analgesia is injected into the pudendal nerves in the pelvis via the vagina. This is occasionally performed to provide pain relief during an instrumental birth.

Shoulder dystocia: the failure of the baby’s shoulders to be born following the birth of the head. This is an emergency situation.
**Syntocinon**: a synthetic version of oxytocin, the hormone that initiates contractions of the uterus during labour. It is used to augment and induce labour, and following a post birth haemorrhage.

**Ventouse**: a suction cup placed on the baby’s head during birth to apply traction and assist the delivery. It is used if the baby is not descending, and/or there is suspected fetal distress.
Chapter 1

Introduction

This thesis tells the story of a research study which explored midwifery practice during birth. Through the birth stories of mothers and midwives it presents and discusses a narrative of midwifery practice. The narrative was shaped by the stories of the participants, my own story, and the broader social context of current midwifery care. This chapter introduces the reader to the background of the study. It explains why the study was undertaken, and provides an overview of how the research was approached. Key terms relating to the thesis are defined and explained. Finally the structure of the thesis is outlined.

THE BEGINNING OF THE STORY

The starting point for most midwifery research is practice (Cluett & Bluff, 2006), and this study originated from my own experience of midwifery practice. As a midwifery student I was taught to perform a variety of routine practices during birth, and I was assessed on my ability to perform these practices. Some of the practices were documented in workplace guidelines and policies, for example, fetal heart rate auscultation and maternal observations. Other practices were not documented but were an expectation within the workplace, for example, telling women when and how to push their baby out; techniques aimed at preventing perineal tearing; and checking for a nuchal cord. I often felt discomfort at having to perform practices when I could not understand the rationale for doing so, nor find supporting research evidence in the literature. However, I continued to perform them because I had no alternative clinical experience to draw upon. In addition, I was aware that my midwifery practice was judged by my ability to perform these actions, and I was required to follow workplace guidelines.

As a qualified midwife I was able to develop my own practice and became more confident in my ability as a midwife, and more importantly, in women’s ability to birth without me telling them how, or doing things to them. Whilst I continued to
perform the clinical assessments detailed in hospital policies, I began to eliminate other practices that were workplace norms. As I did less, I learned more about birth by observing women birthing their babies instinctively, without instruction or physical intervention. I discovered that birth is a physiological process and I learned how not to disturb it. Working alongside other midwives I was aware that my approach was considered unusual, and that the practices I had originally been taught were still commonplace. I was considered ‘weird’ and even ‘dangerous’ by some colleagues because I did not practice in a way that was aligned with the cultural norm of the workplace. In an attempt to explain and justify my approach to practice I reviewed research literature and brought it into the workplace to share with colleagues. However, this only served to alienate me further. Instead I became interested in why midwives carried out particular practices during birth regardless of research evidence. I wondered how women experienced midwifery practice during birth. Perhaps there were reasons that midwives performed particular actions during birth that were unrelated to research evidence. It was with these questions in mind that I began my research journey.

The significance, aim and focus of the research

The overall aim of undertaking this study was to increase midwives’ understanding of their practice in order to improve women’s experience of birth. The experience of birth can have far reaching implications for a woman’s sense of self (Budin 2001; Callister 2004; Cheyney 2011; Halldórsdóttir & Karlsdóttir 1996a; Kennedy & Shannon 2004; Lundgren 2005; Simkin 1991). Interactions, actions, and perceived support from midwives can influence women’s experience of birth (Anderson 2010; Bergström 1997; Halldórsdóttir & Karlsdóttir 1996b; McKay, Barrows & Roberts 1990; Waldenstöm 1999). Birth as a normal physiological process, the avoidance of unnecessary intervention, and being ‘with woman’ are central concepts to a midwifery philosophy of care (Australian Nursing and Midwifery Council 2008a; International Confederation of Midwives 2005; 2010). Hunter (2002, p. 650) carried out a literature review examining the concept of being ‘with woman’ during labour, and as a result defined it as ‘the provision of emotional, physical, spiritual and psychological presence/support by the caregiver as desired by the laboring [sic] woman’. Therefore understanding women’s needs and how best to meet them is fundamental to midwifery practice.
Previous research has focused primarily on physical outcomes relating to specific practices (Hofmeyr et al. 2008). Considering the importance of women’s experience of birth, there has been relatively little research investigating their experiences (Anderson 2010; Beech & Phipps 2004). In particular there appears to be limited research examining women’s physical, psychological, and emotional experience of midwifery practices during an uncomplicated birth. Clement, Wilson and Sikorski (1999) developed an ‘intrapartum intervention score’ based on women’s experiences throughout labour. However, this research examined practices carried out to manage perceived deviations from the norm such as catheterisation, caesarean section, and episiotomy. The routine and ‘invisible’ midwifery practices used during an uncomplicated, normal birth were not included. My research is unique because it examined practices carried out by midwives during uncomplicated births including the overt practices, and the tacit practices previously overlooked (Anderson 2002). Overt practices are those that are itemised and routine; whereas tacit practices are embedded in the experience but not articulated. It explored midwives’ motivations for their practice, and their experience of being with women during birth. In addition, the research examines midwifery practice from the perspective of women; and the study is aligned with the recommendations of the International Confederation of Midwives (2008a, pp. 1-2) regarding midwifery research:

Midwives design/participate in studies that support and promote holistic care as well as evaluating the effects of using technology as an intervention during pregnancy and birth.

The findings of my research add a valuable dimension to the understanding of midwifery practice that can be used to inform midwifery care, and ultimately improve women’s experience of birth and birth outcomes.

I set out to explore midwifery practice during uncomplicated normal births. Following a review of the literature three main research questions were identified:

1. What practices do midwives carry out during birth?
2. Why do midwives carry out particular practices during birth?
3. How do women experience midwifery practice during their birth?
In order to address these questions I required two groups of participants: Midwives who had recently attended an uncomplicated normal birth, and mothers who had recently experienced an uncomplicated normal birth. In order to distinguish between the participant groups they are referred to as ‘midwives’ and ‘mothers’ throughout this thesis.

**Narrative and feminism**

The methodology used for the research was narrative inquiry. Stories and storytelling are embedded in the culture of midwifery, and in the culture of women’s knowledge sharing (Coates 2007; Leamon 2009; McHugh 2007; Wickham 2004). Therefore, a narrative approach seemed a natural way in which to engage midwives and mothers in the research process. In addition, stories can reveal the complexities of human behaviour and enhance understanding of people in their environments (Howie 2010a; Pinnegar & Daynes 2007). Narrative inquiry allowed me to explore the experiences, actions, motivations, interactions and interpretations of participants.

I also took a feminist approach to the research process, and it can be argued that a feminist approach is particularly relevant to midwifery research, as Hunt (2004, p. ix) states:

> Childbirth is a woman’s issue and I have always wondered why anyone could possibly believe that childbirth and midwifery, in particular, could be studied without some reference or even a mention of feminist framework.

Midwifery is predominantly a female profession (Australian Institute of Health and Welfare 2012), childbirth is a female experience, and midwifery care is focused on the needs of women (Australian Nursing and Midwifery Council 2008b; International Confederation of Midwives 2010). Donovan (2006) argues that in order to be consistent with the concept of being ‘with woman’, midwives should work to adopt a feminine model of knowledge, knowledge acquisition and practice. Barnes (1999) suggests that there are two important main principles underlying feminist approaches to midwifery research. Firstly, that the research is conducted for the benefit of women. Secondly, that the research is perceived as a means of social change, i.e. to the organisation and culture of the maternity system.
THE RESEARCHER’S STORY: A SUBPLOT

Reflexivity was an important element of the research process and is aligned with both a narrative, and a feminist approach to research. Reflexivity helps to situate a study and increase understanding of the topic being investigated (Finlay 2003). According to Malterud (2001, p. 484) ‘preconceptions are not the same as bias, unless the researcher fails to mention them’. Therefore, I aim to situate myself within the research from the beginning of this thesis to provide the reader with an understanding of the preconceptions I brought into the study. I am a mother and a midwife who has experienced birth from both perspectives. My philosophy of birth is informed by my experiences, and influences my approach to midwifery and research. I believe that birth for most women can be a normal, healthy, physiological and instinctive process. The role of the midwife is to remain focused on the woman’s needs and intervene only when necessary rather than routinely. I also believe that midwifery should be informed by principles of evidence-based practice. To avoid confusing knowledge embedded in my preconceptions with knowledge emerging from the data, reflexivity was essential throughout the research process (Malterud 2001).

The research story told within this thesis did not occur in isolation. It was interwoven with stories and subplots from my own, and participants' lives. Indeed, the research story would not exist without the many untold stories it was a part of. An overview of my own midwifery story occurring alongside the research may assist the reader to further understand my preconceptions, and my approach to the study. Shortly before commencing my PhD candidature I emigrated from the United Kingdom to Australia. I struggled to fit into an Australian maternity system that was very different to the system I was used to. I found myself working with colleagues who were affronted by my ‘unusual’ approach to practice. My need to understand midwifery practice became stronger and I embarked on my research journey. Eventually, I left hospital practice and became a homebirth midwife in an attempt to practice midwifery in a way that I felt was authentic to my philosophy. However, unlike the in the United Kingdom, homebirth in Australia occurs largely ‘outside’ of the maternity system; and being a midwife on the ‘outside’ was a new and challenging experience. I also began teaching at university, which enabled me to access midwifery students’ experiences and perceptions of midwifery practice. As I gathered and analysed research data, I attended births and became immersed in the local homebirth community, whilst maintaining
connections with hospital midwifery via students. This influenced my approach to
the research and participants’ perceptions of me as a researcher.

DEFINITIONS AND EXPLANATIONS OF KEY TERMS

Labour, birth and stages

In this thesis both the terms ‘labour’ and ‘birth’ will be used to describe the
process during which a woman’s cervix opens and her baby moves through her
body into the external world. ‘Birth’ is often used to describe the emergence of
the baby from the vagina, with ‘labour’ as the process leading up to birth.
However, it is common for both terms to be used to describe parts of the process,
and the entire process (birthing, labouring, in labour, birthed). Therefore this
thesis uses both ‘labour’ and ‘birth’ to reflect the interchangeable nature of the
terms.

In current midwifery texts labour is divided into three distinct
stages, and further divided into phases within those stages (Howie 2010b, 2010c, 2010d; Baddock
2010). The first stage of labour involves regular and coordinated uterine
contractions accompanied by cervical dilatation. This stage includes three
phases: latent, active and transitional. The second stage of labour ‘begins when
the cervix is fully dilated and ends when the fetus is fully expelled from the birth
canal’ (Baddock 2010, p. 533). Again, the second stage is further broken down
into three phases: latent, active and perineal. ‘The third stage of labour is the
period from the birth of the baby through to delivery of the placenta and
membranes and ends with the control of bleeding’ (Baddock 2010, p. 547).
Deconstructing birth into separate parts allows practitioners to measure progress
through stages and create limits and boundaries around what is considered
‘normal’.

Initially my research focus was on the second stage of labour and my project title
at confirmation of candidature was ‘an exploration of midwifery practice during
the second stage of labour’. During the research process it became apparent that
this narrow focus was somewhat naïve and limiting. The stories that women
shared reflected their own interpretation of where their individual birth story
began and ended. Midwives also shared birth stories that began in pregnancy,
and told me about their practice during all stages of birth. I began to realise I was
approaching the research from a medical paradigm. The concept of distinct, measurable stages of labour does not reflect the physiology of birth, nor reflect women's experience of birth (Dixon, Skinner & Foureur 2012). In addition, routinely setting boundaries for labour progress based on clinical assessments of stages is not supported by current research (Lavender, Hart, Smyth 2012). Anderson (2007, p.54) argues that by continuing the discourse of ‘stages’ midwives are ‘adding to the myth of childbirth as a scientific, modern, quantifiable process’ which is neither true to midwifery nor to birthing women. Therefore, I expanded the focus of my study to include the entire experience of birth as defined by participants.

Uncomplicated, normal birth

The term ‘normal birth’ can be problematic. The International Confederation of Midwives (2008b, p. 1) define normal childbirth as:

A unique dynamic process in which fetal and maternal physiologies and psychosocial contexts interact (with the goal of mother and baby being well). Normal birth is where the woman commences, continues and completes labour with the infant being born spontaneously at term, with cephalic birth presentation, without any surgical, medical, or pharmaceutical intervention, but with the possibility of referral when needed.

However, it can be argued that in an Australian context, and in many countries worldwide, ‘normal’ is not the ‘norm’. According to recent Australian National perinatal statistics, only 37% of women labour without induction or augmentation; and it is unclear how many of these women also go on to give birth unassisted (Li et al. 2012). Overall, 44% of women have their birth assisted with forceps, ventouse or caesarean section. Statistics are not provided regarding the percentage of women who give birth to their placenta without medication or assistance. Considering that prophylactic oxytocic medication and controlled cord traction is advocated as standard practice in maternity guidelines (New South Wales Health 2010; Queensland Health 2012), it is likely to be few. Therefore, medical intervention during birth is the norm in Australia, and it is abnormal for a woman to experience an entirely physiological birth. In addition, women
themselves may perceive their birth to be ‘normal’ despite undergoing surgical, medical or pharmaceutical intervention.

For the purposes of my research and this thesis, the definition of a ‘normal birth’ is: an uncomplicated, vaginal birth that begins and progresses spontaneously. I acknowledge that the interpretation of what constitutes ‘uncomplicated’ is also open to debate. For example, a planned caesarean section can be ‘uncomplicated’ whilst a ‘normal’ birth as defined above may involve complications. However, my purpose was to explore what midwives do during a birth that does not require their intervention. I wanted to know what midwives do when there is no medical reason to do anything. I also excluded births occurring with an epidural analgesia for two main reasons. Firstly, an epidural anaesthesia significantly alters the physiology and the experience of birth (Brancato, Church & Stone 2008; Hidaka & Callister 2012; Lieberman et al. 2005). Secondly, midwives care for women with an epidural differently because of the effects of the analgesia (Tracy 2010).

**Midwifery practice**

**Midwives**

This study explored midwifery practice occurring in Australia, therefore it is important to define midwifery, and provide an overview of current Australian midwifery. The International Confederation of Midwives’ core documents and statements underpin the Australian Nursing and Midwifery Council’s codes and guidelines for midwifery practice. According to the International Confederation of Midwives’ (2011) the international definition of a midwife is:

...a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title ‘midwife’; and who demonstrates competency in the practice of midwifery.
The International Confederation of Midwives (2011) also provide a statement regarding the scope of midwifery practice:

The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife’s own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The International Confederation of Midwives recommend a midwifery philosophy and approach to care that is essentially ‘woman centred’ and holistic in nature. There is also an emphasis on the relationship between mother and midwife. For example the International Confederation of Midwives (2010) statement of belief maintains that: ‘midwifery care takes place in partnership with women and is personalised, continuous and non-authoritarian.’ The philosophy is underpinned by the belief that childbearing is a profound but normal experience ‘which carries significant meaning to the woman, her family, and the community’ (p. 1). The Australian Nursing and Midwifery Council (2008b, p. 1) reflect this philosophy in the Code of Professional Conduct for Midwives with the principle ‘midwives practise within a woman-centred framework’.

**Practice**

The focus of this thesis is the practices that midwives carry out at every birth with the intent of monitoring, improving or assisting the physiological process. In The Macquarie Dictionary (2010, p. 649) definitions of ‘practice’ include a ‘habitual or customary performance’ and ‘the action or process of performing or doing something’. Therefore, for the purpose of this study, ‘midwifery practice’ means the actions or behaviours that midwives routinely or perform or display during birth. These regular and customary practices are distinct from interventions carried out in response to an apparent need, for example, to manage a shoulder dystocia, or a haemorrhage.
In relation to normal uncomplicated birth the International Confederation of Midwives (2005) state that midwives will ‘avoid unnecessary interference in the progress of normal labour and birth’ and ‘use technology during childbirth only when indicated, to enhance the well-being of mothers and babies and improve outcomes’. Therefore, midwifery practice does not involve carrying out assessments, interventions and procedures that are not in the best interest of the mother and baby. Leap’s (2010) concept of ‘the less we do the more we give’ is consistent with the philosophy of midwifery discussed above. Leap (2010, p. 18) maintains that midwifery practice:

1. Minimizes disturbance, direction, authority, and intervention.
2. Maximises the potential for physiology, common sense and instinctive behaviour to prevail. 3. Places trust in the expertise of the childbearing woman. 4. Shifts power towards the woman.

The context of Australian midwifery practice

Midwives in Australia work in a range of settings including private obstetric units, public hospitals; birth centres; community clinics; and women’s homes (Commonwealth of Australia 2011). Over 96% of women in Australia give birth in a hospital setting, of those most (70%) via the public health care service (Li et al. 2012). A small but increasing number of women give birth in birth centres (2.2%) or at home (0.5%). It can be argued that these statistics may reflect the services available rather than women’s preference. Maternity care in Australia is ‘generally managed by medical professionals (regardless of the level of risk of the women), with midwives providing secondary assistance’ (Australian Health Ministers’ Conference 2008, p. 3). However, in response to consumer demand there is a governmental commitment to increasing access to midwifery-led continuity of care for women across Australia.

Evidence-based practice

Tensions between ‘evidence’ and practice are discussed within this thesis. In recent years there has been a move towards evidence-based practice across many disciplines including midwifery, and there is a professional expectation that midwives will use evidence to inform their practice (Australian Nursing and Midwifery Council 2008b; International Confederation of Midwives 2008b). The concept of evidence-based practice originated in the development of ‘evidence-
based medicine’ by Archie Cochrane in the 1970s (Clarke & Langhorne 2001; King 2005; Shah & Chung 2009). In his seminal work ‘effectiveness and efficiency: reflections on health services’ Cochrane (1972, p. 1) argued that ‘all effective treatment must be free’. In order to determine the effectiveness of treatments Cochrane proposed the use of randomised controlled trials. After his death, the Cochrane Collaboration was founded based upon the principles of evidence-based medicine (Shah & Chung 2009).

The terms ‘evidence-based’ and ‘research-based’ are used interchangeably throughout the literature (Axford et al. 2004). However, the notion that ‘evidence-based’ means purely ‘research-based’ does not align with the vision of early advocates for evidence-based medicine. Sackett et al. (1996, p. 71) define evidence-based medicine as ‘the conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients’ which involves:

…integrating individual clinical expertise with the best available external clinical evidence from systematic research. By individual clinical expertise we mean the proficiency and judgment that individual clinicians acquire through clinical experience and clinical practice.

Therefore, the clinician blends research evidence with his or her own expertise. Sackett et al. (1996, p. 71) go on to warn that evidence-based medicine should not be ‘cookbook medicine’ and must take into account patients’ choice. In addition they state that:

Evidence based medicine is not restricted to randomised trials and meta-analyses. It involves tracking down the best external evidence with which to answer our clinical questions.

In relation to midwifery, Wickham (1999) maintains that research is not the only valid form of evidence that can be used to inform practice. She argues that because definitions of evidence-based practice originate in medical practice they tend to focus on scientific research evidence dismissing other forms of evidence. Wickham suggests the term ‘evidence-informed’ is more appropriate for midwifery models of care. This involves merging different forms of evidence (research, experience, intuition etc.) with the needs of the woman and the context of the situation.
STRUCTURE OF THE THESIS

This thesis consists of nine chapters. Chapter 1 introduced the background and significance of the research and provided definitions of key terms. Chapter 2 reviews the literature regarding midwifery practice during birth. Chapter 3 outlines the research methodology, and establishes why narrative inquiry is an appropriate research method. Chapter 4 provides an introduction to the findings which are then presented in the following three chapters. Chapter 5 presents the findings about women’s experience of birth. This chapter underpins the following findings chapters by presenting women’s experience of birth, thereby providing a context from which to explore midwifery practice. Chapter 6 and Chapter 7 present findings about midwifery practice. Chapter 8 discusses the contribution of the findings to the literature and theory regarding midwifery practice during birth. Chapter 9 concludes the thesis and presents recommendations for practice and further research.

CONCLUSION

This chapter provided an introduction to the research. The beginning of the research journey was discussed along with an overview of the methodology and approach. Myself as the researcher was situated in the study, and the importance of reflexivity to the research process introduced. Key terms were defined and discussed and the structure of the thesis was outlined.
Chapter 2

Literature review

INTRODUCTION

This chapter presents a literature review carried out and maintained throughout the study. Reviewing the literature assisted me to develop a greater understanding of what was already known; methodologies used; and existing gaps in the body of knowledge. In addition, I was able to refine my research objectives and questions. The literature review comprises of three parts. The first part focuses on research evidence relating to specific practices performed during birth. The aim of this part was to review the literature underpinning routine midwifery practices to provide a foundation on which to explore practice further. The second part of the review explores midwifery practices from the perspective of midwives. The aim of this part was to review literature regarding what midwives do during birth and what influences their practice. The third part of the review examines women’s experience of midwifery practice during birth. The aim of this part was to review midwifery practice from the perspective of women. The three parts of the review provide a holistic examination of the literature surrounding midwifery practice during birth.

In the previous chapter I asserted that the concept of ‘stages of labour’ is inconsistent with women’s experience of birth. However, the terminology relating to stages is used in this review reflecting the continued use of the concept within the literature.

Literature was searched using a systematic method to ensure that all relevant research was included in the review. Whilst a number of databases were searched, the primary database used was MIDIRs On-line because it contains specifically midwifery related research. The literature obtained was then placed into categories and the reference lists checked for further related literature. The literature identified in the reference lists was obtained and their reference lists
checked. Eventually saturation occurred and no further literature was identified. The literature review was maintained and updated throughout the research process, as new publications became available.

PART ONE: COMMON ROUTINE PRACTICES PERFORMED DURING BIRTH

This part of the literature review discusses research regarding outcomes relating to specific routine practices carried out during birth, and provides a foundation for the subsequent parts of the review. It determines the research evidence relating to common midwifery practices during birth and provides a foundation for part two and part three of the literature review. Common practices were identified from literature (Anderson 2002; Baston & Hall 2009; Johnson & Taylor 2010; Thorpe & Anderson 2010), personal observations of clinical practice, and discussions with midwives and midwifery students. The review focuses on uncomplicated birth rather than complicated birth when interventions may be required. Key midwifery practices identified were: maternal observations; fetal heart rate auscultation; assessment of contractions; vaginal examinations; suggesting birth positions; directing pushing; methods to protect the perineum; checking for a nuchal cord; and traction to assist with the birth of the baby's shoulders.

The practices discussed in this section were introduced prior to research examining their effectiveness. Therefore, this literature review focuses on research carried out in a culture whereby the practices studied are already the norm. It is also important to consider that the vast majority of these studies were conducted in hospitals. Therefore, the findings may not apply to births occurring outside of a hospital setting, or outside of institutional guidelines and policy. A range of practitioners are involved in caring for women in labour, including midwives, obstetricians, and intrapartum nurses, and this was reflected in the literature. Therefore, the term 'birth attendant' will be used in this section to refer to the person caring for the woman during labour. For this section, the focus is on practices, rather than the practitioner. The literature reviewed is mainly quantitative as most studies on this topic area seek to measure particular outcomes related to practices.

For a number of the practices identified there was either very little research evidence, or no research at all. For example, regular assessments of maternal observations (pulse, blood pressure, temperature) and contractions are a feature
of clinical guidelines. However, attempts to find research underpinning the guidelines leads the reader to further guidelines. For example, Queensland Maternity and Neonatal Clinical Guidelines (Queensland Health 2012) reference the National Institute for Clinical Excellence guidelines (NCCWCH 2007) and the World Health Organization (2006a). The World Health Organization do not provide a reference to support their guidance and the National Institute for Clinical Excellence guidelines state that no relevant research was identified. There are also currently no studies specifically exploring the use of traction to assist with the birth of the baby’s shoulders, and systematic clinical reviews of second stage management do not even refer to the practice (Hofmeyr et al. 2008). However it remains in textbooks (Baston & Hall 2009; Johnson & Taylor 2010) and appears to be a common practice. Guidelines recommend routine vaginal examinations during labour to assess the progress of cervical dilatation (NCCWCH 2007; Queensland Health 2012; World Health Organization 2006a). This assessment is recorded on a partogram to determine ‘normal’ progress and provide a basis for augmentation of labour. A Cochrane review on ‘the effect of the partogram use on outcomes for women in spontaneous labour at term’ concluded that ‘we cannot recommend routine use of the partogram as part of standard labour management and care’ (Lavender, Hart & Smyth 2012, p. 2). However, the review goes on to conclude that since the partogram is in widespread use, its use should be locally determined until stronger evidence is available. Therefore, it appears that practices introduced without research evidence to support their implementation continue until research is carried out to support their discontinuation. On the other hand, research is not the only form of evidence for practice (Wickham 2004), and these practices may have evolved based on another form of evidence.

Research has been conducted examining some routine practices carried out during birth. These include auscultation of the fetal heart rate; directed pushing; suggesting birth positions; protecting the perineum; and checking and managing a nuchal cord. The remainder of this section reviews this literature.

1 National Collaborating Centre for Women’s and Children’s Health
Auscultation of the fetal heart rate

Listening to the fetal heart is a practice dating back as far as the 1800s (Goodwin 2000; Maude, Lawson & Foureur 2010), and today auscultation of the fetal heart rate is routinely carried out throughout most labours. There are two methods of assessing the fetal heart rate, continuous electronic monitoring using a cardiotocograph, and intermittent auscultation using a Doppler or pinnard. Studies comparing the two methods have consistently demonstrated that for low risk women, continuous electronic monitoring increases interventions such as caesarean section and instrumental birth, without improving neonatal outcomes (Cheyne et al. 2003; Devane et al. 2012; Graham et al. 2006; Kelso et al. 1978; MacDonald et al. 1985; Mires, Williams & Howie 2001; Neldam et al. 1986; Vintzileos et al. 1995; Wood et al. 1981). Therefore, it is generally accepted that intermittent auscultation is the most appropriate method of assessing the fetal heart rate for low risk women in labour (Queensland Health 2012; RANZCOG 2006). Intermittent auscultation involves listening to, and counting fetal heart sounds through the mother’s abdomen at regular intervals during labour (Maude, Lawson & Foureur 2010; Goodwin 2000). The use of a Doppler can identify fetal heart rate abnormalities more reliably than a pinnard (Day, Maddern & Wood 1968; Mahomed et al. 1994), and is more commonly used in hospital settings. The recommended frequency of intermittent auscultation is generally stated in clinical guidelines as every 15-30 minutes during the first stage of labour, increasing to after every contraction or every five minutes during the second stage (Queensland Health 2012; RANZCOG 2006; World Health Organization 2006a). However, there has been no research to date examining whether the practice of fetal heart rate auscultation is beneficial, or the optimal frequency of auscultation.

The practice of intermittent auscultation is based on the notion that by listening to fetal heart rate patterns during labour, fetal distress can be identified. It can be argued that this practice has become established because experiential evidence supports the association between fetal heart rate patterns and fetal wellbeing. Clinical guidelines recommend the use of intermittent auscultation for all women during labour (Queensland Health 2012; World Health Organization 2006a). The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (2006, p. 6) state that ‘intermittent auscultation is recommended as a minimum for

2 Royal Australian and New Zealand College of Obstetricians and Gynaecologists
women who, at the onset of labour, are identified as having a low risk of developing fetal compromise’. The evidence for recommendation is graded as ‘A’. An ‘A’ graded recommendation ‘requires adequate randomized controlled trial evidence as part of a body of literature of overall good quality and consistency addressing the specific recommendation’ (RANZCOG 2006, p. 16). However, the evidence cited by RANZCOG is a Cochrane review comparing continuous electronic monitoring with intermittent monitoring (Thacker, Stroup & Chang 2001), rather than research comparing no monitoring with intermittent monitoring. The NCCWCH (2007) guidelines state that they were unable to identify any good quality studies to support auscultation.

In an earlier guideline the Royal College of Obstetricians and Gynaecologists (2001) cite a study by Kauntiz et al. (1984) as the primary source of evidence supporting the need to auscultate the fetal heart during labour. Kauntiz et al. (1984) compared perinatal and maternal death rates amongst members of a religious group in Indiana, with rates for non-members. The group members received no prenatal care and gave birth at home without trained attendants. Their maternal mortality rate was 100 times higher, and their perinatal mortality rate was three times higher than non-members. Trauma, asphyxia at birth and respiratory problems accounted for most of the perinatal deaths. However, autopsies were performed in only 19% of cases, for the remaining 81% the identification of a cause of death relied upon reports from the county coroner. Over half of the deaths occurred in babies who weighed less than five pounds, therefore cannot be considered healthy full term babies (Coad & Dunstall 2011). The researchers conclude that a lack of medical care during birth contributed to the high level of maternal and perinatal mortality. The study does not address antenatal care, or the overall health of the women in the religious group. It is unclear how the results provide evidence specifically supporting intermittent auscultation during labour. Therefore it can be argued that an evidence grade of ‘A’ by RANZCOG (2006) is unjustified. However, again it can be argued that a lack of evidence does not necessarily indicate that a practice is not effective. Listening to the fetal heart during labour provides an indication of the baby’s well-being and is supported by a body of experiential and theoretical knowledge (Thorpe & Anderson 2010).

Practice guidelines recommend increasing the frequency of auscultation in the second stage of labour because the baby is considered to be at greater risk of
becoming hypoxic (Queensland Health 2012; RANZCOG 2006; World Health Organization 2006a). Umbilical artery pH levels provide an indication of fetal hypoxia, and babies with pH levels of less than 7.00 are significantly more likely to experience morbidity and mortality (van den Berg et al. 1996). Cord pH levels have been found to fall during the second stage of labour (Hagelin & Leyon 1998; Yoon & Kim 1994), and the recommended increase in fetal heart rate auscultation is based upon this notion (RANZCOG 2006). However, this fall in pH may be associated with Valsalva type pushing (see ‘directed pushing’ p. 18) rather than the second stage of labour alone (Thomson 1993). In any case, the small decline in pH identified in studies does not disadvantage a healthy full term baby who begins the second stage with normal pH levels (Yoon & Kim 1994).

There is still relatively little known about how events occurring during labour influence neonatal morbidity. Adamson et al. (1995) found that hypoxia during labour was not the cause of neonatal encephalopathy in the majority of the cases they studied. They suggest that the aetiologies of neonatal encephalopathy may originate in the antenatal period. Gaffney et al. (1994) found that an ominous fetal heart rate pattern in the second stage of labour was associated with cerebral palsy, however, two thirds of babies with cerebral palsy had normal fetal heart rate patterns. Another study by Nelson and Grether (1998) found that indicators of fetal distress such as abnormal heart rate patterns and meconium liquor were common during labour in both healthy babies and babies with cerebral palsy. Therefore, identifying a normal fetal heart rate pattern or an abnormal pattern during labour is not particularly useful in identifying babies at risk of morbidity following birth.

The effectiveness of using fetal heart rate patterns to assess fetal well-being is even more questionable during the second stage of labour. It can be argued that abnormal patterns during the second stage of labour may be considered normal. Sheiner et al. (2001) found that 75% of fetal heart rate traces showed abnormal patterns during the second stage of labour. However, abnormal patterns were only associated with poor outcomes if there were also abnormal patterns present during the first stage of labour. Studies by Loghis et al. (1997) and Wu, Chen, and Wang (1996) also found that abnormal heart rate patterns during the second stage were only significant when associated with abnormal patterns during the first stage. The fetal heart rate pattern that provides the most accurate prediction of fetal hypoxia is prolonged reduced variability (Gull et al. 1996; Williams &
Galerneau 2003), however intermittent auscultation is ineffective at identifying heart rate variability (Harrison 2004; Miller, Pearse & Paul 1984; Schifrin, Amsel & Burdorf 1992). Therefore, auscultating the fetal heart during the second stage is likely to identify abnormal patterns that are normal, and is unlikely to identify abnormal patterns that may be significant. When an abnormal heart rate pattern is identified guidelines recommend commencing continuous electronic fetal monitoring (Queensland Health 2012; RANZCOG 2006). Considering that abnormal fetal heart rate patterns occur in most second stages, this may result in the majority of women undergoing continuous monitoring.

**Directed pushing**

Midwives often direct women’s pushing behaviour during the second stage of labour. (Osborne & Hanson 2012; Peterson & Besuner 1997; Sampselle et al. 2005; Thomson 1993; Walsh 2000). Directed pushing involves encouraging the use of a particular method of pushing after full dilatation of the cervix has been identified. Women are often instructed to use Valsalva pushing or a variation of this method which involves: taking a deep breath as a contraction begins; holding the breath by closing the glottis; bearing down forcefully for eight to ten seconds; quickly releasing the breath; taking another deep breath and repeating this sequence until the contraction has ended (Barnett & Humenick 1982; Paine & Tinker 1992; Parnell et al. 1993; Peterson & Besuner 1997; Sampselle et al. 2005, Yildirim & Beji 2008). Valsalva pushing has been found to have a number of effects on women including: impeding venous return; increasing intrathoracic pressure (Taggart et al. 1992); raising intraocular pressure (Rafuse et al. 1994); increasing arterial pressure (Haykowsky, Findlay & Ignaszewski 1996); affecting flow velocity in the middle cerebral artery (Tieks et al. 1995); and altering body-fluid pH contributing to inefficient uterine contractions (Roemer & Vogel 1994). Valsalva pushing also affects the baby by reducing placental blood flow and subsequently increasing the risk of hypoxia (Aldrich et al. 1995; Bassell, Humayun & Marx 1980; Caldeyro-Barcia et al. 1981).

The instructions given during directed pushing do not reflect the progression of an undirected second stage. For example, full dilatation of the cervix alone may not be responsible for initiating expulsive contractions. Instead, the urge to push has been associated with the position of the baby’s head in the pelvis (Roberts et al. 1987), and has been found to vary between women (McKay, Barrows &
Roberts 1990). Based on this evidence Cosner and de Jong (1993) argue that the second stage of labour should be defined as beginning with explosive contractions, rather than beginning with full dilatation of the cervix. In an attempt to describe the progression of an undirected second stage Aderhold and Roberts (1991) observed videotapes of births. They identified three separate phases: the lull, active bearing down, and the perineal phase. However, a number of methodological concerns cast doubt on the validity of these findings. The sample size consisted of only four women, and the level of intervention was high. One woman had a syntocinon infusion, two women gave birth in lithotomy, and two women were given an episiotomy. Therefore, the women in the study underwent interventions that may have altered the progression of their second stage. Birth attendant’s communication has been found to contribute significantly to how women behave during the second stage (Sampselle et al. 2005) and, although birth attendants in Aderhold and Robert’s (1991) study were told not to provide directions, the encouragement given by those present may have influenced women’s behaviour. One father chanted “PushPushPushPushPushPush…." (p. 274) during contractions, and a birth attendant is quoted as saying “That’s a girl. That’s a girl" (p. 269) during pushing efforts. Therefore, there remains inadequate research into the progression of an undisturbed second stage.

Valsalva type pushing does not appear to reflect how women push when undirected. Studies exploring spontaneous pushing behaviour have made a number of observations that are in contrast with the directions given by birth attendants. Rossi and Lindell (1986) found that most women did not use closed glottis pushing, and instead used open glottis pushing or intermittently exhaled during pushes. Roberts et al. (1987) also found that most women did not hold their breath whilst pushing, and those that did, held it for less than six seconds. Women gave much shorter pushes and took several breaths between each push. Over half of all pushes were accompanied by a transient fall in the baby’s heart rate, and the researchers suggest that the breaths taken between pushes may help to oxygenate the baby and counteract the effects of pushing. The number of pushes per contraction increased as the second stage progressed, and women instinctively altered their pushing according to their contraction pattern. For example, if contractions were infrequent women tended to use more pushes per contraction, and if contractions were frequent they pushed less often. A later study by Thomson (1995) supports these findings and provides further evidence that women’s spontaneous pushing behaviour varies considerably from the
instructions given during directed pushing. Women in the study did not
commence pushing at the start of contractions, nor take a deep breath in before
pushing. They altered their pushing behaviour throughout the second stage and
used a mixture of closed glottis and open glottis pushing. The number of pushing
efforts per contraction also varied, with some women not pushing at all during
some contractions.

Initially directed pushing was introduced to shorten the duration of the second
stage in an attempt to protect the baby from the perceived risks of a long second
stage (Barnett & Humenick 1982; Beynon 1957; Bosomworth & Bettany-Saltikov
2006; Peterson & Besuner 1997; Woolley & Roberts 1995). However, the
premise that directed pushing reduces the duration of the second stage is
uncertain. A number of studies comparing directed with undirected pushing
support this (Bloom et al. 2006; Perry & Porter 1979; Thomson 1993; Woolley &
Roberts 1995). Although, the women in Thomson's (1993) directed pushing
group also had shorter first stages, which cannot be attributed to pushing
method, and may have influenced the duration of the second stage. Other studies
fail to identify a significant difference in the duration of the second stage between
directed and undirected groups (Knauth & Haloburdo 1986; Paine & Tinker 1992;
Parnell et al. 1993; Sampselle & Hines 1999; Yeates & Roberts 1984). One study
found that directed Valsalva pushing significantly increased the length of the
second stage (Yildirim & Beji 2008). However, it can be argued that there are
methodological problems inherent in any study attempting to determine the
duration of the second stage. Duration relies on the identification of full dilatation
of the cervix during a vaginal examination (Reed 2011; Robertson 2002). This
examination may be carried out minutes or hours after actual full dilatation,
resulting in a great deal of variation in the time at which the second stage is
diagnosed and the subsequent timing of duration.

The premise that a longer second stage increases the risk of complications for
the baby is also uncertain. Whilst some studies identify an association between
the duration of the second stage and complications (Hellman & Prystowsky
1952; Katz et al. 1987; Roemer et al. 1976; Wood et al. 1973), more studies
found no relationship (Cohen 1977; East, Dunster & Colditz 1998; Hagelin &
Leyon 1998; Janni et al. 2002; Piper, Bolling & Newton 1991; Menticoglou et al.
1995; Moon, Smith & Rayburn 1990; Sampselle et al. 2005; Saunders, Paterson
& Wadsworth 1992; Suzuki & Okudaira 2004). Two studies found that although a
second stage lasting over one and a half hours was not associated with a poor outcome for the baby, it did increase the risk of maternal morbidity such as third and fourth degree tears, episiotomy, operative delivery, chorioamnionitis, and haemorrhage (Cheng, Hopkins & Caughey 2004; Myles & Santolaya 2003). However, some maternal and neonatal morbidity may be related to the interventions used to end a prolonged second stage such as an operative delivery. Another difficulty encountered when reviewing these studies is that the method of pushing is not described. Because Valsalva type pushing is common, outcomes may be influenced by the prolonged use of this method rather than the duration of the second stage alone.

Studies comparing directed pushing with undirected pushing provide additional information about the influence of pushing method on neonatal and maternal outcomes. All comparison studies use directed pushing as the control group, demonstrating the routine nature of this practice, and they set out to demonstrate it is safe and effective to allow women to follow their own urges rather than to demonstrate the effectiveness of directed pushing. Umbilical cord pH is often used as an indicator of fetal stress during labour, and in randomised controlled trials. Paine and Tinker (1992) and Parnell et al. (1993) found no difference in cord pH between directed and undirected groups. However, it can be argued that neither study examined genuine undirected pushing. The women in Paine and Tinker’s (1992) experimental group were directed to give short pushes with a slight exhale rather than being left to push spontaneously. Parnell et al. (1993) state that 65.5% of the women in their undirected group used Valsalva type pushing. They conclude: ‘this seems to imply that the ‘good old’ policy of instructing women to use the forced expulsion routinely is congruent with the natural pushing technique in a majority of women’ (p. 34). However, this conclusion is not in keeping with the findings of studies examining women’s spontaneous pushing behaviour (Roberts et al. 1987; Rossi & Lindell 1986; Thomson 1995). There were also high levels of birth interventions evident in this study that may have influenced how women pushed in the undirected group. For example, almost half of the women had a pudendal block which may have altered their sensations and spontaneous pushing behaviour. A more recent study by Yildirim and Beji (2008) aimed to compare spontaneous pushing with Valsalva pushing and found that the spontaneous group had a shorter second stage, better Apgar scores and cord pH levels, and the women expressed greater satisfaction with their pushing technique. However, the spontaneous group
received specific instructions (open glottis and push while breathing out) and support to follow this technique. Therefore it can be argued that these women were not truly pushing spontaneously, but following a different set of instructions that may reflect undirected pushing more closely than Valsalva pushing.

Comparative studies suggest that spontaneous pushing may protect babies from stress during the second stage. Four studies found a reduction in indicators of stress for babies during and immediately following birth with undirected pushing (Barnett & Humenick 1982; Knauth & Holburdo 1986; Yeates & Roberts 1984; Yildirim & Beji 2008). Knauth and Holburdo (1986) also noted that women who had been dropped from their study because they had undergone a caesarean during the second stage were more likely to have been using Valsalva pushing. They suggest that prolonged Valsalva pushing may prevent the normal gradual descent and rotation of the baby and lead to maternal fatigue and metabolic acidosis. Thomson (1993) found that there was a negative correlation between the duration of the second stage and umbilical cord pH only with directed pushing. These findings support Roberts et al.’s (1987) notion that women instinctively alter their breathing to oxygenate their baby when undirected.

Directed pushing also appears to be associated with maternal morbidity, in particular damage to the perineum (Albers et al. 2006; Sampselle & Hines 1999; Yeates & Roberts 1984), and the pelvic floor (Beynon 1957; Prins et al. 2011; Schaffer et al. 2005a). These findings suggest that the practice of directing pushing itself may be responsible for the neonatal and maternal outcomes associated with a long second stage.

Directed pushing was introduced in an attempt to shorten the duration of the second stage of labour in the belief that this would improve neonatal outcomes. The practice of closed glottis or Valsalva pushing became common practice in the absence of research evidence demonstrating its effectiveness. There have been a number of studies examining pushing in the second stage, and a number of systematic reviews have been generated based on these studies (Bosomworth & Bettany-Saltikov 2006; Hofmeyr et al. 2008; McKay 1985; Prins et al. 2011; Roberts & Hanson 2007; Thomson 1988). Despite methodological issues with some research, the findings and recommendations remain fairly consistent. Valsalva type pushing does not reflect women’s spontaneous pushing behaviour. Directing women to use this method of pushing may or may not shorten the duration of the second stage. However, reducing the duration of the second stage
does not improve neonatal outcomes. Indeed the Valsalva method of pushing may increase morbidity for both mother and baby. Therefore, the practice of directing pushing has not been shown to do more good than harm, and based on the current research evidence should not be used routinely by midwives. Instead, evidence supports the notion that most women instinctively push in the most effective and safe way for themselves and their babies.

Suggesting birth positions

Midwives often suggest birth positions to women during the second stage of labour (Anderson 2002). Very little is known about the positions women instinctively use when undirected, although there is some evidence that historically women birthed in up-right positions and still do in many parts of the world (Kitzinger 2000). The medicalisation of birth resulted in women labouring on beds and using positions that benefited birth attendants (Donnison 1988). This cultural expectation of birthing whilst reclining on a bed may now influence the positions women use when undirected, making research in this area difficult. The only study that observed women birthing in a non-prescriptive environment found that almost half chose a reclining position with a lateral position as the next most frequent choice (Rossi & Lindell 1986). It may have been interesting to interview these women prior to labour about their expectations regarding birth positions.

A Cochrane review of ‘maternal positions and mobility during first stage of labour’ found a reduction in the length of the first stage of labour for women who were upright or walking; and a reduction in the use of epidural analgesia (Lawrence et al. 2009). However, there was no difference in other outcomes measured such as augmentation or assisted delivery. Most studies examining birth positions compare the outcomes related to different positions during the second stage. A Cochrane review (Gupta Hofmeyr & Shehmar 2012) analysed randomised or quasi-randomised trails. Twenty two trials were included and the use of any upright or lateral position during the second stage was compared with a supine or lithotomy position. The authors warn that due to the methodological quality of the trials the results of the review should be interpreted with caution. However, the review found no significant difference between the duration of the second stage. Women birthing in an upright position had a reduced rate of assisted birth, fewer episiotomies, a reduction in the experience of severe pain, and fewer fetal heart rate abnormalities. They also experienced an increased risk of having an
estimated blood loss over 500mls. However, some trials included in the review used birth stools or squatting stools in upright positions that had a receptacle to collect blood loss. The authors suggest that this may have influenced results by providing a more accurate measure of blood loss in upright positions.

A study by de Jong et al. (2007) explored the causes of this increased estimated blood loss in upright positions. They found that semi-sitting or sitting upright positions only led to an increase in estimated blood loss when women had sustained perineal damage. Studies have set out to identify associations between birth position and perineal damage. For example, Soong and Barnes (2005) analysed data from 3756 births and found a semi-recumbent birth position was associated with the need for perineal suturing whereas an all-fours position was associated with a reduced need for suturing. These associations were more marked for women experiencing their first vaginal birth and with babies weighing over 3.5kg. Altman et al. (2007) also found that a kneeling birth position reduced the risk of perineal damage from both tears and episiotomy. Gottvall, Allebeck and Ekéus (2007) conducted an observational cohort study of 12,782 women and found that the use of lithotomy and squatting during birth increased the risk of anal sphincter tears. A number of studies examining risk factors for perineal damage have also identified birth position as a factor. Positions associated with an increased risk of perineal damage are squatting (Shorten, Donsante & Shorten 2002), a supine position (Mayerhofer et al. 2002), and the use of lithotomy (Albers et al. 1996; Hastings-Tolsma et al. 2007). Positions associated with a reduced risk of perineal damage are lateral positions (Albers et al. 1996; Hastings-Tolsma et al. 2007; Shorten, Donsante & Shorten 2002) and for women having their first baby, a kneeling or hands and knees position (Murphy & Feinland 1998). In contrast, Ragnar et al. (2006) conducted a randomised controlled trial of 218 women, comparing sitting with kneeling. The primary objective was to compare the duration of the second stage and the researchers found no differences in duration between the two positions.

**Protecting the perineum**

According to Australian perinatal statistics two thirds of women sustain damage to their perineum during birth (Li et al. 2012). For most women this consists of tearing or grazing, and for around 12% the damage is caused by an episiotomy. Midwives use particular techniques in an attempt to protect the perineum from
trauma during birth. The most commonly used techniques are: instructing women to stop pushing (or pant) as the baby’s head is born; applying pressure to the baby’s head; and applying pressure to the perineum (Johnson & Taylor 2010; Queensland Health 2012; World Health Organization 2006a). These practices are aimed at slowing down the birth of the baby’s head to allow perineal tissues to stretch whilst providing support to the perineum to avoid tearing.

There appears to be no research directly examining the use of verbal instructions to protect the perineum. However, a study by Albers et al. (2006) found that the birth of the baby’s head between contractions reduced the risk of perineal trauma. They conclude that birthing the baby’s head between contractions requires a joint effort by the mother and her clinician. These findings suggest that instructing women to stop pushing may help to prevent perineal damage. On the other hand, women may do this instinctively if left to follow their own urges during birth. Aderhold and Robert’s (1991) studied four women birthing without instructions and found that they all began to breathe faster rather than pushing as the baby’s head crowned. This suggests that instructions from midwives may be unnecessary, as women will spontaneously slow down the birth of their baby’s head. However, more research is required into women’s instinctive behaviour during an undirected birth.

Research has been carried out examining the physical interventions midwives use to protect the perineum. The most common of these involves the midwife using her hands to slow down and control the birth of the baby’s head and/or supporting the perineum (World Health Organization 2006a). A number of studies have examined whether such hands on techniques reduce perineal trauma. A prospective study by Murphy and Feinland (1998) of 1068 homebirths found that perineal support reduced the risk of tearing for primiparous women. However, only 27.6% of births involved no manual support of the perineum and only 8.5% involved no intervention at all. Therefore, the results may have been different if the groups had been randomised. A large randomised controlled trial by McCandlish et al. (1998) compared ‘hands poised’ with ‘hands on’ in 5741 births and found no difference in perineal tears between the two groups. However, the hands on group had a higher rate of episiotomy and the hands poised group had an increased rate of manual removal of placenta. They also found that women in the hands poised group reported more perineal pain on day ten (mostly ‘mild’ pain). Methodological issues are raised by the researchers that should be
considered when reviewing these findings. Before the study, the majority of midwives felt more comfortable with the hands on method, which may explain the non-compliance level of 29.1% in the hands off group. Also, one third of the women in the study knew their randomisation, which may have influenced their responses to the questionnaire.

Mayerhofer et al. (2002) conducted a smaller randomised controlled trial involving 1161 women allocated to either ‘hands on’ or ‘hands off’ management. The ‘hands on’ group had a significant increase in third degree tears and episiotomies. The researchers suggest that the increased episiotomy rate supports McCandlish et al.’s (1998) findings, and implies that a policy of using an intervention brings with it an increased risk that further intervention will follow. They go on to hypothesize that the increase in third degree tears may be a result of perineal ischemia caused by the midwife applying additional pressure to the tissues with her hands. Another small randomised controlled trial in Mexico found that a hands on approach did not affect the frequency or severity of perineal trauma for primiparous women (Costa & Riesco 2006). However, in a review of the study, Albers and Borders (2007) argue that the sample is too small to ascertain any true differences in outcomes. Hastings-Tolsma et al. (2007) found that flexion and/or counter pressure on the emerging head, and manual support of the perineum provided protection against perineal tears. However, the study involved descriptive analysis of data from the late 1990s, and there is no record of the proportion of women who did not receive hands on management. Considering hands on techniques are the norm, the number of hands off data available for analysis may have been very small. More recently, Aasheim et al. (2012) carried out a meta-analysis of 8 studies to explore ‘perineal techniques during the second stage of labour for reducing perineal trauma’. They concluded that there was no difference between ‘hands on’ vs ‘hands off’ in the prevention of perineal tearing. However, they found that a ‘hands on’ approach was associated with a greater risk of episiotomy. The reviewers noted that there are considerable clinical variations between what the terms ‘hands on’ and ‘hands off’ mean.

Research has identified factors other than verbal instruction and hands on techniques that may influence perineal outcome. These factors can be placed into two main groups, fixed factors and unfixed factors. Fixed factors that increase the risk of perineal trauma include: a large baby (Albers et al. 2006;
Dahlen et al. 2007; Groutz et al. 2011; Lydon-Rochelle, Albers & Teaf 1995; Mayerhofer et al. 2002; Nodine & Roberts 1987; Shorten et al. 2002; Soong & Barnes 2005); a higher weight gain during pregnancy; Caucasian ethnicity; higher socioeconomic circumstances; older maternal age (Murphy & Feinland 1998; Shorten et al. 2002); Asian ethnicity (Dahlen et al. 2007; Goldberg et al. 2003) and first vaginal birth (Dahlen et al. 2007; Groutz et al. 2011; Murphy & Feinland 1998; Nodine & Roberts 1987; Shorten et al. 2002; Soong & Barnes 2005).

Whilst birth attendants cannot control fixed factors, they are able to influence unfixed factors.

Unfixed factors that increase the risk of perineal trauma include: directed pushing (Prins et al. 2011; Sampselle & Hines 1999; Schaffer et al. 2005a); the use of analgesia and anaesthesia (Carroll et al. 2003; Hastings-Tolsma et al. 2007; Lydon-Rochelle, Albers & Teaf 1995; Nodine & Roberts 1987; Soong & Barnes 2005) an instrumental birth (Dahlen et al. 2007; Groutz et al. 2011) a supine, squatting or lithotomy birth position (Mayerhofer et al. 2002; Shorten et al. 2002). Unfixed factors that reduce the risk of perineal trauma, particularly for primiparous women, include lateral, kneeling or hands-knees birth positions (Albers et al. 1999; Hastings-Tolsma et al. 2007; Murphy & Feinland 1998; Soong & Barnes 2005); and antenatal perineal massage (Albers et al. 2005; Beckmann & Garrett 2006). The application of perineal warm packs may reduce the incidence of third or fourth degree tears and reduce postnatal pain and urinary incontinence (Aasheim et al. 2012; Dahlen et al. 2007; Hastings-Tolsma et al. 2007). Aasheim et al. (2012) also found that perineal massage during birth reduced the risk of third and fourth degree tears occurring. Therefore, there may be practices that increase or decrease women’s risk of tearing during birth.

**Checking for and managing a nuchal cord**

It is routine practice to feel for a nuchal cord following the birth of the baby’s head by inserting a finger into the woman’s vagina, and running a finger over the baby’s neck to identify cord (Jefford, Fahy & Sundin 2009a; Schorn & Blanco 1991). If a cord is found, its tightness determines further intervention. A loose cord is usually pulled and looped over the baby’s head, but when the cord is too tight for this maneuver it is often clamped, cut and unwound before the birth of the baby’s body (Jackson, Melvin & Downe 2007; Mercer, Skovgaard & Erickson-Owens 2008; World Health Organization 2006a). The incidence of a nuchal cord
at birth has been reported in a number of studies and found to occur in between 10-37% of births (Adinma 1990; Clapp III et al. 2003; Ghosh & Gudmundsson 2008; Mastrobattista et al. 2005; Miser 1992; Peregrine, O’Brien & Jauniaux 2005; Rhoades, Latzu & Mueller 1999; Schaffer et al. 2005b; Sheiner et al. 2006), although two studies conducted in India found rates as low as 2.1% (Kumari et al. 1992) and 5.74% (Dhar, Ray & Dhall 1993). Nuchal cords also appear to be more prevalent in male babies (Adinma 1990; Martin, Green & Holzman 2005; Rhoades, Latzu & Mueller 1999), perhaps because males are more likely to have longer umbilical cords making entanglement more probable (Rogers et al. 2003). The incidence of a nuchal cord occurring during pregnancy increases with gestation (Ghosh & Gudmundsson 2008; Larson, Rayburn & Harlan 1997). However, Rhoades, Latzu and Mueller (1999) found that nuchal cords were found less frequently during elective caesareans suggesting that they may also form during labour.

Two studies linked the presence of a nuchal cord during pregnancy with mild chronic prelabour hypoxia (Hashimoto & Clapp 2003) and a lower birth weight (Miser 1992; Rhoades, Latzu & Mueller 1999). Other studies found no association between nuchal cords and morbidity during pregnancy (Askoy 2003; Carey & Rayburn 2000; Clapp III et al. 2003; Gonzalez-Quintero et al. 2004). Most research in this area focuses on the effect of a nuchal cord during labour and birth. Some studies found no significant effects (Gonzalez-Quintero et al. 2004; Miser 1992; Peregrine, O’Brien & Jauniaux 2005), and Sheiner et al. (2006) found a lower perinatal mortality rate in babies with nuchal cords. Mastrobattista et al. (2005) found a higher caesarean section rate for babies without a nuchal cord. However, the retrospective data included elective caesareans, therefore this finding may support Rhoades, Latzu and Mueller’s (1999) theory that some babies become entangled in their cord during labour.

The majority of studies examining outcomes found an association between a nuchal cord during labour and fetal heart rate abnormalities, operative delivery, lower cord pH, lower Apgar scores and admission to special care nursery. However, a number of problems arise when attempting to interpret these results. Firstly, there may be a recording bias. Greenwood and Impey (2002) carried out a study comparing a hospital where the presence of a nuchal cord was routinely recorded at every birth with other hospitals where recording was at the discretion of the birth attendant. When recording was discretionary, the presence of a
A nuchal cord was associated with lower Apgar scores and cerebral palsy. However, this association was absent when nuchal cords were routinely documented. These findings suggest that birth attendants are more likely to document the presence of a nuchal cord when there is evidence of neonatal compromise. Secondly, many studies do not distinguish between a loose nuchal cord and a tight nuchal cord (Assimakopoulos et al. 2005; Clapp III et al. 2003; Hankins et al. 1987; Martin, Green & Holzman 2005; Rhoades, Latzu & Mueller 1999; Schaffer et al. 2005b; Sheiner et al. 2001; Sørnes 1998). All of the research studies that do differentiate found the association with complications was only related to tight nuchal cords (Adinma 1990; Dhar, Ray & Dhall 1995; Kumaria et al. 1992; Larson et al. 1995; Nelson & Grether 1998). Lastly, the common practice of clamping and cutting tight nuchal cords may be a factor in the reported complications. In three of the studies that differentiated between loose and tight cords, a tight cord was defined by the need to clamp and cut. The other two studies did not provide information regarding the management of nuchal cords, therefore it may be assumed that at least a proportion of the cords were clamped and cut.

It can be argued that there are risks associated with clamping and cutting an umbilical cord prior to birth. The woman must be prevented from pushing which may be difficult and uncomfortable, the baby may be inadvertently cut, and if the cord is clamped improperly the cord could bleed (Reed, Barnes & Allan 2009; Schorn & Blanco 1991). Once the cord is clamped, blood flow between the baby and placenta is interrupted reducing the baby’s blood volume and oxygen supply, risking hypovolemia and hypoxia (Mercer et al. 2005). Therefore, it may be the management of a nuchal cord that causes lower umbilical cord pH, lower apgar scores, the need for resuscitation and anaemia, rather than the presence of a nuchal cord. Mercer et al. (2005) suggest that a tight nuchal cord may compromise a baby during labour because compression of the cord during contractions can prevent normal blood flow and the correction of acid-based imbalance. They argue that if the cord is left intact, once the baby is born the placental circulation can correct the acid-based imbalance. Any necessary resuscitation can take place with the assistance of the placental circulation perfusing the baby and improving their blood volume and oxygenation. Schorn and Blanco (1991) describe a ‘somersault technique’ that can be used to assist the birth of a baby with a tight, short nuchal cord without clamping and cutting.
Another risk involved in clamping and cutting a nuchal cord is the possibility of a shoulder dystocia occurring. Once the cord is cut a delay in the birth of the baby may cause morbidity or mortality. Iffy, Varadi and Papp (2001) carried out medico legal reviews of nine cases where the umbilical cord was cut after the birth of the baby’s head prior to a shoulder dystocia. The cases resulted in serious injuries to the babies and malpractice actions against the doctors involved. The writers conclude that the practice of cutting the cord prior to the birth of the body is dangerous and should be avoided. The potential benefit of an intact cord during a shoulder dystocia is illustrated in a case study described by Flamm (1999). In this case the nuchal cord was not cut and the baby was eventually delivered by caesarean section after being pushing back into the vagina using cephalic replacement. If the nuchal cord had been cut, this baby may not have survived such drastic action.

Whilst research has concentrated on the outcomes associated with a nuchal cord, there has only been one study to date examining the management of a nuchal cord. Sadan et al. (2007) carried out a randomised controlled trial of 60 births involving a nuchal cord. In one group the cord was cut after the birth of the anterior shoulder, and in the other group the cord was left intact. The study only included babies with the cord around their neck once, and did not distinguish between tight and loose cords. They found no difference in fetal heart rate abnormalities, cord pH or Apgar scores at one minute, and conclude that cutting a nuchal cord does not adversely affect the baby. However, it can be argued that these findings are limited to babies who are not compromised by their nuchal cord. Babies with tight or multiple nuchal cords are more likely to be compromised and would benefit most from leaving the cord intact. In the group that had their nuchal cord left intact, the cord was looped over the baby’s head and if it was too tight to loop it was left alone. This implies that some babies were born with the cord remaining around their neck, casting doubt on the need to loop cords at all. Pulling and looping a loose nuchal cord is a common midwifery practice (Jackson, Melvin & Downe 2007). However, there is a lack of research examining this practice, and some evidence that it may be harmful. For example, handling the cord stimulates the umbilical arteries to vasoconstrict reducing blood flow (Coad & Dunstall 2011), and in waterbirths this practice is contraindicated (Johnson & Taylor 2010). Any pulling also creates tension on the umbilical cord risking avulsion and subsequent neonatal bleeding (Reed 2007; Schorn & Blanco 1991). There is an absence of adequate evidence to support looping or cutting a
nuchal cord, and it can be argued that the practice of checking for a cord is unnecessary if no further action will be taken.

**PART TWO: MIDWIVES AND PRACTICE DURING BIRTH**

The previous section reviewed research relating to specific practices and their outcomes. Determining whether research supports a particular practice assists with exploring why midwives carry out that practice. This second part of the literature review focuses on practice from the perspective of midwives. Firstly, literature examining what a midwifery philosophy of care is, and whether this philosophy supports common routine practices is reviewed. Then, how the context of midwifery care influences practice will be examined. Finally, literature addressing how midwives acquire knowledge and develop practice is discussed. Although most of the literature reviewed involves midwives, some research carried out in the United States involves intrapartum nurses. This research has been included because intrapartum nurses maintain a similar philosophy of care to midwives, and they care for women during birth (Sleutal 2003). In contrast to the previous section, the research reviewed is mostly qualitative in nature.

**The midwifery philosophy of care and midwifery practice**

It can be argued that being ‘with woman’ and expert midwifery care does not include carrying out routine actions. Kennedy (Kennedy 2000; Kennedy et al. 2004) conducted a three-stage study to define the critical elements unique to exemplary midwifery care. The Delphi method was used to analyse narratives of exemplary midwives and the women they cared for. It was apparent that the exemplary midwives supported normalcy and only intervened when necessary. Kennedy (2000, p. 12) describes this approach as ‘the art of doing ‘nothing’ well’. Downe, Simpson and Trafford (2006) carried out a systematic review and meta-synthesis to determine what comprises expert maternity care. They found three intersecting concepts: wisdom, skilled practice, and enacted vocation. Wisdom is an acceptance of uncertainty and an awareness that each birth process is individual. Skilled practice is a reflexive competence and not reliant upon protocols or routine techniques. Enacted vocation includes the belief that birth is physiological and women have the capacity to birth. In a secondary analysis of qualitative studies, Lundgren and Berg (2007) identified six central concepts in the mother-midwife relationship. Each concept includes one aspect from the
mother’s perspective and one responsive aspect from the midwife. These concepts are surrender / availability, trust / mediation, participation / mutuality, loneliness / confirmation, differenceness / support, uniqueness and creation of meaning / support meaningfulness. MacLellan (2011) carried out a discourse analysis of midwifery practice and identified four concepts of fundamental skill: ‘presence’, ‘guardianship’, ‘intuition’, and ‘confidence and courage’ of the midwife. According to these studies, midwifery care supports the normal process of birth, and actions are carried out in response to individual needs rather than on a routine basis.

However, there is an absence of literature examining what differentiates support from intervention. To intervene is to ‘come between in action’ (The Macquarie Dictionary 2010, p. 438), in this case, coming between the instinctive and physiological process of birth. It can be argued that according to this definition, many of the practices reviewed in the first section of this literature review are interventions. However, such actions may be considered supportive. For example, Mittner (2000) explored maternity nurses views of intrapartum labour support using a descriptive survey design in which specific actions were listed as being ‘supportive care’. Ranked at number two was ‘coaching mother during pushing efforts’ (p. 495). Therefore, coaching women during pushing was considered a supportive action rather than an intervention. Roberts et al. (2007) analysed communication between birth attendants and women, and identified seven rationales for implementing directed pushing in an attempt to support women. The rationale ‘maternal fear’ included women who used mini pushing and open glottis pushing for less than three seconds. However, this is normal behaviour and does not require the intervention of directed pushing (Roberts et al. 1987; Rossi & Lindell 1986; Thomson 1995). In the study, descriptions of ‘supportive direction’ include, ‘take another deep breath and get in another push, if you have it’, and ‘try it like that and hold your legs’ (p. 138). It can be argued that these directions represent an intervention rather than being supportive of women’s instinctive pushing behaviour. There was a high rate of epidural use amongst the women in the study which may have influenced care and the use of directed pushing (Bevis 1997). However, both of the above studies serve to highlight the problems involved in differentiating support and intervention.
The context of midwifery care

The context of midwifery care may influence midwifery practice, and midwives’ ability to implement changes to practice. In a study examining cord clamping practices, Mercer, Nelson and Skovgaard (2000) found that midwives would follow hospital routines and policies regardless of their own beliefs or research regarding best practice. Stewart (2001) interviewed maternity providers (midwives, nurses and obstetricians) about their perceptions of evidence-based practice. The findings suggest that the dominant culture within the health service affects the way in which evidence is interpreted and used. Participants felt that the culture was medical and focused on technology and abnormality. Although this view of birth was attributed to obstetricians, it was considered that many midwives also subscribed to the perception of birth as abnormal.

Stewart (2001) found that midwives encounter difficulties implementing evidence-based practice if the evidence (or lack of) does not conform to the cultural norm of the workplace. Routine practices during labour are a cultural norm, therefore midwives may find it difficult to change their practice, even with adequate evidence available. O’Connell and Downe (2009) conducted a metasynthesis of 14 studies relating to midwives’ experience of hospital practice. They identified three overarching themes: ‘power and control’; ‘compliance with cultural norms’; and ‘attempting to normalise birth’. The midwives struggled to provide the type of care they wanted due to the workplace culture and heavy workloads. A study by Keating and Fleming (2009) explored midwives’ experiences of facilitating normal birth on an obstetric-led unit. From the midwives’ narratives they identified four concepts of patriarchy: ‘hierarchical thinking’, ‘power and prestige’, ‘a logic of domination’ and ‘either/or thinking’. These themes are very similar to those found in O’Connell and Downe’s (2009) study. In addition, the midwives considered that scientific knowledge was valued over ‘women’s ways of knowing’.

Some studies have identified ‘risk’ as a rationale underpinning midwifery practice. Surtees (2010) conducted a discourse analysis of 40 interviews with midwives and found that ‘defensive practice’ within a ‘culture of risk’ emerged as a theme. Midwives carried out practices in order to minimise risk for the woman, baby and themselves. Fenwick et al. (2012) also found that newly qualified midwives struggled to provide woman-centred care within the risk-averse culture of maternity care. Individual routine practices have been found to be risk based, for example, auscultating the fetal heart and checking for a nuchal cord (Jefford,
Stewart (2008) found that midwives' performance of vaginal examinations was influenced by the 'surveillance' of hospital staff and policies. Surtees (2010) also found that midwives would carry out practices in order to provide evidence that they were performing as required within the hospital system.

Being unable to align practice with beliefs and philosophy can be a source of emotional stress for midwives (Fenwick et al. 2012; Licquirish & Seibold 2008; O'Connell and Downe 2009). Hunter (2004) carried out an ethnographic study to explore how a range of midwives experienced and managed emotions in their work. She identified two competing occupational identities and ideologies, 'with woman' and 'with institution'. When midwives were able to work according to a 'with woman' ideal they found their work emotionally rewarding. However, if they were unable to do so, they found their work emotionally difficult. Hunter (2004) concluded that conflicting ideologies were a source of 'emotion work' for midwives. Midwives who attempt to align practice with their woman-centred philosophy are often subjected to workplace ridicule and bullying (Bluff & Holloway 2008; Fenwick et al. 2012; Lewis & Rowe 2004; Licquirish & Seibold 2008; O'Connell & Downe 2009; Stewart 2001). However, midwives employ a number of strategies to cope with working within a medicalised system in which they are subordinate. In an exploration of midwifery mentors, Bluff and Holloway (2008) identified two main types of midwife, 'prescriptive' and 'flexible'. Flexible midwives were able to maintain their subordinate position whilst deceptively practising in a way that maintained their philosophy of care and autonomy. They achieved this by remaining silent and using secrecy and deception to exercise autonomy and provide woman-centred care. Peterson and Busuner (1997) also found that midwives in their study openly discussed the strategies they used to delay providing information to obstetricians in order to avoid unnecessary intervention for women.

Kent (2000) suggests that some midwives redefine their role as technical and clinical in an attempt to gain status within a medical culture. Bluff and Holloway (2008) found that unlike the flexible midwives in their study, prescriptive midwives rigidly followed rules, and therefore prescribed the care that women received. Obstetricians were their role models and guidelines, cultural norms and routine practices were followed regardless of evidence or individual need. By conforming, prescriptive midwives were able to get into positions of power allowing them to
intimidate and bully flexible midwives, and maintain the cultural norm of the maternity system. Flexible midwives perpetuated this culture by remaining silent, and only one midwife in Bluff and Holloway’s study admitted to challenging the power of a prescriptive midwife. The lack of support she received from other flexible midwives ensured she would remain silent in the future.

A dominant medical birth culture may also influence how midwives frame their own research questions. An Australian study was undertaken by a midwife in an attempt to reduce the instrumental birth rate for ‘failure to progress’ in a particular hospital (Phipps, Charlton & Dietz 2007; 2009). A randomised controlled trial was carried out in which the experimental group of women were given two antenatal education sessions teaching them how to push effectively. These sessions included a vaginal examination to ensure they learned the correct pushing technique. The quantitative analysis found no difference in obstetric outcomes. This study was carried out despite research evidence against time limits in the second stage, against directed pushing, and evidence in favour of spontaneous pushing (Bosomworth & Bettany-Saltikov 2006; Hofmeyr et al. 2008; McKay 1985; Prins et al. 2011; Roberts & Hanson 2007; Thomson 1988). The research focused on improving women’s ability to push their baby out within specified time limits, rather than questioning such time limits. It can be argued that the fact this study was conducted demonstrates the influence of a medical culture over midwifery.

**Midwifery knowledge, experience and practice**

The cultural norm of the workplace also influences the education of midwives before and after qualification. In the last decade midwifery education moved into the university setting with placements in the clinical area. It was hoped that this would raise clinical standards by developing practitioners who are evidence-based, and assist in professionalising midwifery (James & Willis 2001). However, midwifery students encounter conflict between what they learn at university and the expectations of the workplace. Whilst university education focuses on a midwifery philosophy of care and evidence-based practice, the clinical area focuses on the performance of tasks, and meeting the needs of the maternity system. Begley (2001) found that midwifery students perceived the clinical setting as being monotonous and governed by routines with little emphasis on evidence-based practice. Students often found themselves performing tasks without
understanding the rationale for them. The integration of evidence into practice was not encouraged. Instead clinical education appeared to focus on ensuring students were competent at carrying out routines that supported the cultural norm.

Bosanquet (2002) describes how midwifery students undergo a process of ‘organisational socialisation’ whereby they assimilate into the organisation by absorbing its values, accepting the peer structure, and modifying their own behaviour. Bluff and Holloway (2008) found that students observed and emulated the practice of their mentors whether they were flexible or prescriptive midwives. Emulating prescriptive midwives was easy because they provided clear instructions about when and how things were done. Flexible midwives incorporated evidence into their practice and demonstrated individualised care. However, students became confused by the lack of clear and standard instructions. Flexible midwives told students not to copy their practice because it would result in conflict with prescriptive midwives. Although the intention was to protect the student, the message was confusing. Students also witnessed how flexible midwives were criticised and intimidated by prescriptive midwives and learned that if they practiced as flexible midwives, they too would be humiliated. Licquirish and Seibold (2008) found that students attempted to avoid becoming socialised into a midwifery culture that was not aligned with the philosophy they learned in university. They did this by seeking out opportunities to work with midwives who imbued the philosophy they admired. It can be argued that once midwives qualify they have more freedom to develop their practice, as they no longer have to please their clinical mentors. However, newly qualified graduates continue to be disappointed that their working environment does not align with their university education (Fenwick et al. 2012; Lewis & Rowe 2004; Siebold 2005).

A midwife’s personal experience also influences their practice. Soong, Jacobs and Barnes (2001) conducted a study of midwives’ practices at the time of birth. They found that midwives’ practice was influenced by observing other midwives, their own clinical experience, and by gaining confidence in their ability. Most participants appeared bound to cultural norms rather than research evidence, and none of the practices they used to protect the perineum were cited from research. They also considered their personal comfort to be an influence in their practice. For example, in the case of birth position, many felt that women should
adopt a position that accommodates the midwife, and this position should prevent undue strain on the midwife’s back and allow adequate viewing of the perineum.

A study by Dahlen et al. (2007) found that when midwives were asked to identify reasons for severe perineal trauma they included factors relating to their own experience. For example, delivery technique and lack of communication were considered to cause perineal trauma. Midwives frequently commented that the birth was ‘uncontrolled’ due to problems communicating with non-English speaking women, and felt it was important to tell women to breath as the head is born.

Access to experience also influences midwifery practice. For example, Sampselle et al. (2005) conducted a study exploring provider support during spontaneous pushing in the second stage of labour. They suggest that midwives may have been unable to support spontaneous pushing because they lacked the experience of non-directive communication to draw upon. On the other hand, observation and experience can lead midwives to change their practice. Jackson, Melvin and Downe (2007) examined questionnaires completed by midwives regarding their management of a nuchal cord. Most midwives checked for cord, and managed a nuchal cord either looping it over the baby’s head or cutting it. However, some midwives described how they had changed their practice following observation or experience. For example, one midwife stated that she ‘...was taught to clamp and cut as a student, but having seen two shoulder dystocias after clamping, baby floppy – one brain damaged – now after qualifying, will usually wait...’ (p. 52). Three respondents mentioned that they were less likely to intervene by looping a loose nuchal cord after observing waterbirths where a hands off approach is recommended. Observing a waterbirth of a baby with a nuchal cord without encountering problems provided them with an experience they could translate to births out of water. Jefford, Fahy and Sundin (2009b) also found that midwives altered their practice regarding nuchal cords in response to observing waterbirths. The researchers posted on two online forums asking midwives what their training was, and current practice is regarding nuchal cords. Twenty six midwives responded from 9 countries. Whilst most midwives checked for, and managed nuchal cords, some midwives reported changing their practice in response to experiences such as observing waterbirths. Two midwives changed their practice after noticing the pain it caused women when checking for cord.
PART THREE: WOMEN’S EXPERIENCE OF MIDWIFERY PRACTICE DURING BIRTH

The previous section of the literature review discussed research relating to midwives’ experiences of their practice. It explored practice during birth from the perspective of midwives, and the identified factors that influence their practice. The mother-midwife relationship is central to midwifery practice (International Confederation of Midwives 2010), therefore any exploration of midwifery practice must consider the experience of the woman. This third part of the literature review focuses on research relating to women’s experience of birth, and their experience of midwifery practice during birth.

Letting go

The experience of an altered state of consciousness and the need to ‘let go’ of the mind is identified in many studies exploring women’s birth experience. Beck (1994) examined women’s temporal experiences during birth and found that thought processes changed. Women described their state of mind during birth as strange and disorientated, and their sense of time was altered. Halldórsdóttir and Karlsdóttir (1996a) also found that women in their study indicated that they lost sense of time and felt in their own private world during birth. In a study by Machin and Scamell (1997), women also experienced an altered state during labour, one participant reported that she ‘…lost all track of time. I didn’t know whether it was day or night…’ (p. 82). Anderson (2010) carried out a study exploring women’s experiences of the second stage of labour. Women described severe and intense physical sensations during this time. In order to cope women entered an altered state of consciousness where they could ‘let go’ or disconnect, allowing their body to take control. Fifteen of the sixteen women interviewed talked about a sense of separation of mind from body which enabled them to feel in control. Findings of a pilot study by Parratt and Fahy (2003) also support the notion that women relinquish their mind control and allow their body to lead the birth process. The authors argue that the process of ‘releasing the body’ occurs spontaneously and progressively throughout labour, but can be disturbed easily.

It appears that midwives play an important role in creating an environment in which women can ‘let go’ during birth. All fourteen of the women in Halldórsdóttir and Karlsdóttir’s (1996a) study talked about a perceived vulnerability during the birth experience and about the need to feel safe and secure. The midwife
provided a sense of security which enabled women to let go and follow their body. For some women this sense of security was underpinned by reassurance. For others, it was the mere presence of the midwife that enabled them to let go. Berg et al. (1996) examined women’s experience of their encounter with the midwife during birth. The findings identified ‘presence’ as the essential structure of this encounter. Presence was made up of three themes – to be seen as an individual, to have a trusting relationship, and to be supported and guided on one’s own terms. When midwives addressed these themes, women gained a sense of security allowing them to let go. In this study affirmation appeared to be an essential aspect of supporting women to listen to their own bodies. Anderson (2010) also found that women in her study required their midwives to provide an unobtrusive presence and atmosphere of safety and calm in order to feel secure enough to let go. One woman described the midwife as ‘…the anchor that helps you go off into that altered state…’ (p. 125). Beech (2005) found that women wanted their midwife to be confident in her knowledge of normality and know when to intervene, and when to provide only a watchful presence. Walsh (2006) conducted an ethnographic study of a free-standing birth centre in the UK. He used the term ‘matrescence’ to describe the protective and nurturing presence midwives provided for women.

In contrast, when women perceive their midwife to be absent rather than present it can negatively effect their birth experience. Halldörsdóttir and Karlsdóttir (1996b) found that when the midwife did not physically stay close to the woman it was interpreted as uncaring. The need for the midwife to be physically present in the room is important for many women, but not all. A large quantitative study by Waldenström et al. (1996) found that although almost half of the participants wanted their midwife to be present in the room as much as possible, more than half did not require this level of physical presence. Walker, Hall and Thomas (1995) also found that amongst women birthing in a midwifery-led unit, many expressed a preference to be left alone with their partner during most of their labour. Perhaps the concept of a presence is primarily about a sense of availability rather than a physical presence. Women also consider it important for their midwives to be calm, confident, kind, patient, professional, caring, understanding, supportive, encouraging, comforting, competent, attentive, sensitive, and positive (Bryanton, Fraser-Davie & Sullivan 1994; Czarnocka & Slade 2000; Fowles 1998; Halldörsdóttir & Karlsdóttir 1996a; 1996b; Kennedy 1995). They want their midwives to give praise and encouragement; to assist
them with breathing and relaxing; treat them with respect; to validate their feelings, and connect with them (Bryanton, Fraser-Davie & Sullivan 1994; Fowles 1998; Halldórsdóttir & Karlsdóttir 1996a; 1996b; Lavender, Walkinshaw & Walton 1999; McKay & Smith 1993; Singh & Newburn 2006; Waldenström et al. 1996). In addition, the type of midwifery care a woman receives during birth may have long-lasting effects. Waldenström (2004) found that a lack of supportive care during birth was associated with a reduction in satisfaction with the birth experience over the first year. In contrast sensitive and supportive care was associated with improving satisfaction over the first year.

**Being in control**

A number of studies have identified control as a key factor in women’s experience of birth. For women, a sense of control during birth is associated with a positive birth experience and greater satisfaction (Cheung, Ip & Chan 2007; Gibbins & Thomson 2001; Goodman, Mackey & Tavokoli 2004; Green & Baston 2003; Hall & Holloway 1998; Halldórsdóttir & Karlsdóttir 1996a; Hauck et al. 2006; Lavender, Walkinshaw & Walton 1999; Lundgren 2005; Olsson, Jansson & Norberg 2000; Simpkin 1991; Slade et al. 1993; Waldenström 1999). When women do not experience control during birth they may feel angry, disappointed and suffer long term emotional and psychological consequences (Czarnocka & Slade 2000; DiMatteo, Kahn & Berry 1993; Fair & Morrison 2012; Fowles 1998; Green, Coupland & Kitzinger 1990; Slade et al. 1993; Soet, Brack & Dilorio 2003). It can be argued that there are two main types of control, control of oneself, and control of birth events (O’Hare & Fallon 2011). The need to control oneself may present a paradox when considered alongside the need to ‘let go’. On the one hand women appear to need to release self control, and on the other maintain self control. In a phenomenological study, Lundgren (2005, p. 346) described the experience of birth as ‘an unavoidable situation, which was demanding for both control and loss of control; as going with the flow and at the same time taking command of oneself’. Women also need to feel a sense of control over the events that occur during their birth (Green & Baston 2003; Halldórsdóttir and Karlsdóttir’s 1996a; Lavender, Walkinshaw & Walton 1999). Gibbins and Thomson (2001) explored women’s expectations and experiences of birth. The concept of ‘control’ surfaced as the essence of the study findings. Women wanted to take an active part in their labour, and feeling in control of events was central to this. Feeling a sense of control enabled women to feel
positive about their birth experience, even when it differed from their expectations.

The midwife appears to have a major influence on women’s perceptions of control during birth. Anderson (2010) found that the women in her study were unanimous in their belief that the midwife was critical to their experience of birth, and this centred on issues of control. Women reported positive feelings about their birth experience when their midwife did not take control, and instead facilitated the woman’s own confidence and control. Other studies also support the notion that the interactions and actions of the midwife influence a woman’s sense of control and overall birth experience. A study by Hauck et al. (2006) found that midwives who demonstrated advocacy and acknowledged individual needs and choices, enhanced women’s feelings of confidence and control. In an earlier study, Kennedy (1995) found that women considered their midwife to be an advocate who was prepared to support their choices, even if it meant going against medical opinion. By sharing information, facilitating decision making and supporting choices midwives can increase women’s sense of control during birth (Gibbins & Thomson 2001; Green & Baston 2003; Hall & Holloway 1998; Halldórsdóttir & Karlsdóttir 1996b). Fair and Morrison (2012) found that women cared for by midwives had significantly higher ‘experienced control’ and birth satisfaction than those cared for by obstetricians.

On the other hand, a woman’s perception of control can be decreased by the actions and interactions of her midwife. Midwives who fail to demonstrate the caring and supportive behaviours previously described can leave women feeling insecure and lacking control. Green and Baston (2003) found that for women having their first baby being left alone by their midwife during labour was associated with a significant decrease in their sense of control. These findings demonstrate the importance of a midwifery presence. They also found the sense of control that had the most impact on psychological outcomes was feeling in control of what staff were doing. However, less than 40% of women reported experiencing this type of control. In a survey of 1336 postnatal women conducted by Brown and Lumley (1998) most participants identified that they wanted participation in decision making during their birth. Less than 5% wanted decisions to be made on their behalf. Another study by Berg et al. (1996) found that although women wanted support, encouragement and guidance, they wanted it on their own terms. Anderson (2010) also found that women reported feeling
controlled by their midwife. Six of the sixteen women in her study related their interactions with the midwife as being reminiscent of school. Several were referred to as a ‘good girl’ when they behaved in a way that the midwife approved of. However, more women described a sense of ‘not doing it right’ or failing to meet the expected standard. Some women in Anderson’s (2010) study appeared to consider the adult-child relationship as a given. For example, one woman stated ‘you have to obey and listen to what the midwife’s telling you…’ (p. 124).

Bergstöm et al. (1992) studied interactions between birth attendants and women during the second stage of labour. They identified that vaginal examinations communicated an overall message of the power of the midwife over the labouring woman.

Mother-midwife interactions regarding the diagnosis of labour can generate control issues. Midwives diagnose labour and monitor labour progress according to guidelines and policies underpinned by a medicalised culture. Therefore the assessments centre around the concept of ‘stages of labour’ and notions of progress based upon cervical dilatation (Reed 2011). Dixon et al. (2012) conducted in-depth interviews with 18 women who had experienced an uncomplicated, spontaneous labour and birth and found that women’s perceptions of birth did not include stages. In particular the diagnosis of labour can undermine women’s experience of control. The experience of being assessed as ‘not in active labour’ and sent home can be distressing and result in women feeling unsupported (Baxter 2007; Barnett et al. 2008; Scotland et al. 2011). A study of first time mothers, found that women experienced embarrassment when they arrived at hospital too early to stay, and felt vulnerable when negotiating with midwives to avoid being sent home (Eri et al. 2010). Women perceived midwives as ‘gatekeepers’ who they had to negotiate their credibility with in order to gain access to the hospital. However, Gross et al. (2003; 2006; 2009) found that women’s own assessment of how and when their labour begins was varied and not congruent with midwives clinical diagnosis of labour onset. A study of first time mothers by Low and Moffat (2006) found that women were perceived as abnormal by hospital staff if their experience of labour onset did not fit clinical definitions. Themes identified from the data included ‘this is not right’ and ‘don’t trust your body, trust us’.

In contrast, it can be argued that a relationship whereby the midwife is in control may be reassuring for some women. In the literature this preference for external
control appears to be more common during complicated births (Lavender, Walkinshaw & Walton 1999; Walker, Hall & Thomas 1995). In O’Hare and Fallon’s (2011) study relinquishing control was considered to be a way of retaining control, if the control was relinquished willingly. Carlsson, Hallberg and Pettersson (2009) also found that women were keen to move to hospital once labour started in order to hand over the responsibility of well-being to midwives. The concept of the midwife being ‘the expert’ may contribute to women relinquishing control to them. A study by Bluff and Holloway (1994) of women’s perceptions of midwifery care during birth, identified the core construct as a belief that ‘they know best’. Women trusted the greater knowledge of their midwife and believed that there was a good reason behind any action taken. A study into women’s experience of waterbirth found that a small minority of women felt that relinquishing control of events to the midwife was necessary in order to gain personal control (Hall & Holloway 1998). Therefore, it can be argued for some women the perception of their midwife being in control is important to their birth experience.

**Midwifery practices**

There have been very few studies of women’s experience of specific midwifery practices during an uncomplicated birth. However, there are a number of studies exploring interventions used during a perceived deviation from the norm. Studies have identified an association between interventions and dissatisfaction with the birth experience (Brown & Lumley 1994; Creedy, Shochet & Horsfall 2000; Green, Coupland & Kitzinger 1990). Creedy, Shochet and Horsfall (2000) also found that symptoms of post-traumatic stress disorder after birth were more likely for women who experienced a high level of obstetric intervention. On the other hand, women in a study by Lavender, Walkinshaw and Walton’s (1999) did not perceive intervention as negative.

Women’s knowledge regarding particular practices may also influence research findings. For example, Impey (1999) conducted a survey to determine women’s attitudes to amniotomy and the duration of labour. The survey was given to women in early pregnancy and it asked them to respond to questions such as ‘I want a quick labour’, ‘I want my labour to be as pain free as possible’, ‘I want an epidural’ (p. 212). Based on women’s responses Impey (1999) concluded that women want a quick and painless labour and do not object to the interventions
that achieve this. However, these women had no information regarding the risks and benefits of such interventions. Their responses may have been different if they had been provided with this information. Borders, Lawton and Martin (2012) found that women requested vaginal examinations during labour. Whilst vaginal examinations are commonly performed, there has been little research exploring women’s experience of the assessment. In her PhD thesis Stewart (2008) identified a discourse of ‘discomfort’ expressed by women who found the procedure painful and distressing. A postnatal study of 176 Palestinian women (Hassan et al. 2012) found that 82% reported pain or severe pain during vaginal examinations carried out in labour. A study of Hong Kong Chinese women (Ying Lai & Levy 2002) also found that women experienced vaginal examinations as painful and embarrassing. Therefore the rationale for women requesting such assessments must be explored further. Stewart (2008) found that women were given very little information about vaginal examinations, and when they were in labour there was an apparent assumption that midwives needed to carry out these assessments. It can be argued that there is also a misleading assumption that the findings of a vaginal examination can predict the future progress of labour (Reed 2011).

Some studies have explored women’s experiences of directed pushing. Mackey (1998) conducted a study of women who had previously had a baby. In their evaluation of labour and birth 30% of the women identified pushing as the worst part of the experience. The women who felt they had had difficulty, or had managed their birth poorly reported problems with controlling their urge to push, or not pushing as instructed. These findings are common throughout the literature. It appears that when midwives give instructions that do not match the woman’s own sensations and urges it can lead to confusion and frustration. It can be argued that these conflicting instructions fit into three main categories: preventing pushing until confirmation of second stage; directing the pushing technique; preventing pushing as the baby’s head is born.

The first category of instruction involves midwives preventing women from following their urge to push until full dilatation of the cervix is confirmed by a vaginal examination. A study by Bergström (1997) explored the interactions between midwives and women during the change from first to second stage of labour. One woman pleaded with her midwife ‘please let me push now… No, no, no I gotta push’ (p. 72). Bergström (1997) noted that women who had been
prevented from pushing would often be unable to follow their own urges once they were given permission to push. Women in Anderson’s (2010) and Halldorsdottir and Karlsdottir’s (1996a) studies also described how midwives would often override the woman’s own bodily sensations. In these studies midwives appear to be controlling when women push rather than supporting them to follow their bodily urges.

The second category of instruction involves midwives directing women’s pushing technique. The literature supports spontaneous and instinctive pushing rather than the techniques often dictated by midwives (Bosomworth & Bettany-Saltikov 2006; Hofmeyr et al. 2008; McKay 1985; Prins et al. 2011; Roberts & Hanson 2007; Thomson 1988). Women appear to be aware that there is a conflict between their urges and their midwives instructions. McKay, Barrows and Roberts (1990) found that several women commented that they were not pushing correctly. Women noticed that the instructions did not match what their bodies were instinctively trying to do. Bluff and Holloway (1994) also found that women followed their midwives instructions rather than their own bodies. Two women in McKay, Barrows and Roberts’ (1990) study had homebirths and were not given any pushing directions. One of them explained her belief in her own body: ‘my body knows how to push’ (p.196). These findings link into the discussion above regarding the context of care influencing midwifery practice and subsequently women’s experience.

The third category of instruction involves midwives instructing women to stop pushing as the baby’s head is born in an attempt to protect the perineum. There have been no studies regarding women’s experience of this category of pushing instructions. However, a woman in Anderson’s (2010) study described her experience of this intervention: ‘… I was told not to push and pant, I panted. It’s like being back at school… The midwife is more in control than you think’ (p. 123).

On the other hand, some women may expect their midwife to direct their pushing. Anderson (2010) found that all of the women in her study had clear expectations that the midwife would tell them when they could push. In Parnell et al.’s (1993) study of directed and spontaneous pushing women expressed anxiety about the possibility of being allotted to the spontaneous group. This anxiety centred around being left without instructions for pushing. Two studies ten years apart illustrate how some women expect their midwife to instruct them. One woman in
McKay and Smith’s (1993) study wanted to know how to push and became confused by what she considered to be vague instructions. A similar exchange was described by a midwife in Kennedy’s (2004, p. 557) study, however in this case the midwife went on to convey the woman’s awe at the power she experienced when she began to push in response to her own urges, and her amazement that she had not felt this during her previous births. Women may have expectations that their midwife will direct their pushing, perhaps due to the perception that the midwife knows best.

There has been no research to date specifically exploring women’s experience of fetal heart auscultation. However, Anderson (2010) found that physical interventions intended by midwives to confirm normality sometimes convey the message that there may be problems. Listening to the fetal heart generated concern for some women about their baby’s well-being. This concern interfered with women’s ability to ‘let go’ during birth. Several women talked about being conscious of their baby’s well-being even though their midwives had concerns. They trusted their own instincts and connection to their baby more than the medical technology.

Midwives often suggest birth positions to women, and women’s experience of birth positions has been explored by a number of studies. De Jonge et al. (2011) conducted a postal questionnaire of over three thousand women 3-4 years after birth. They found no relationship between birth position and childbirth satisfaction, self-esteem or emotional well-being. An earlier study involved in-depth interviews with women in an attempt to gain a deeper understanding of the relationship between birthing positions and the labour experience (de Jonge & Lagro-Janssen 2004). The findings from this study provide some evidence regarding women’s perceptions of midwives suggesting birth positions. Eighteen of the twenty women in the study felt it was important for the midwife to provide information on birth positions, and some expected their midwife to do so. Encouragement to find a comfortable position during labour created a sense control for women. Almost half of the women felt they had more control over their pushing during the second stage when in an upright position. Women described how they were able to find the most suitable position through a combination of their own preferences and their midwife’s suggestions. The freedom to adopt positions contributed to a better birth experience and better postnatal emotional well-being. However, women were interviewed by a midwife who had attended their birth, which may
have influenced their responses. Green and Baston (2003) also found that being able to get into a comfortable position increased the feeling of control for women having their second or subsequent baby. It can be argued that being encouraged to find a comfortable position and suggesting a specific position are different. For example, a woman in Halldorsdottir and Karlsdottir’s (1996b) study felt that instructions interfered with her sense of control. Ragnar et al. (2006) conducted a randomised controlled trial of 218 women to compare sitting with kneeling for birth. The women allocated to the sitting group reported higher pain and discomfort during the birth and in the postnatal period; a longer and more difficult second stage; and a reduced sense of control and higher anxiety levels. Further research is needed to explore how midwives can encourage women to follow their bodies and adopt comfortable positions without interfering with their sense of control.

There is no research available specifically exploring women’s experience of practices such as protecting the perineum, checking and managing a nuchal cord, and using traction to assist the birth of shoulders. A systematic review of nuchal cord management found no data regarding women’s experiences of this common intervention (Melvin & Downe 2007). However, Melender and Lauri (1999) carried out a study into fears associated with birth and found that some women expressed concern that the presence of a nuchal cord had caused complications during their birth. This suggests that women may be aware of the existence and management of a nuchal cord during their birth. There is also some anecdotal evidence that checking for nuchal cord is an uncomfortable experience for women (Reed 2007; Wickham 2003). However, further research is required to explore how women experience specific routine interventions during their births.

**SUMMARY OF THE LITERATURE REVIEW**

Many routine midwifery practices are not supported by research evidence. Birth as a normal physiological process, the avoidance of unnecessary intervention, and being ‘with woman’ are central concepts to a midwifery philosophy of care. However, there is uncertainty regarding what differentiates a supportive action from an intervention. The context of midwifery care influences midwifery practice, and makes it difficult for midwives to implement changes to practice that do not conform to the cultural norm of the workplace. The cultural norm of the maternity
system also influences the education of midwives before and after qualification. Studies exploring women's experience of birth have identified an altered state of consciousness and a need to 'let go' of the mind. Midwives play an important role in creating a physical and emotional environment in which women can 'let go' during birth. A number of studies have identified control as a key factor in women's experience of birth. For women, a sense of control during birth is associated with a positive birth experience and greater satisfaction. However, what is meant by 'control' can be difficult to ascertain and may hold different meanings for individual women. There is a need to conduct further research into women's experience of specific midwifery practices during birth.

The majority of the studies reviewed were conducted in hospitals therefore caution must be taken when applying these findings to birth and midwifery practice outside of a hospital environment. There are few studies that explore midwifery practice from both the midwife's and the woman's perspective. Further research is required into midwifery practice during an uncomplicated birth, and how midwifery practice influences women's experiences of birth. My study seeks to address these areas, and this literature review informed my objectives and the development of the research questions: what practices do midwives carry out during birth; why do midwives carry out particular practices; how do women experience midwifery practice during birth? The methodologies in the first section of the literature review were mostly quantitative, reflecting the focus on outcomes. The methodologies used in second and third section of the literature review were primarily qualitative and many involved in-depth interviewing. These sections focussed on midwives' and women's experiences, which required the deeper exploration facilitated by qualitative research. My study also aimed to explore experiences, and a qualitative methodology was appropriate for this purpose.

**CONCLUSION**

This chapter presented a literature review conducted and maintained throughout the research process. The review consisted of three parts. The first part examined literature regarding specific practices carried out during birth. The second part focussed on midwifery practice from the perspective of midwives. The third part explored women's experience of midwifery practice during birth. The review identified the need for further research into midwifery practice during uncomplicated, normal births which includes the perspective of women. In
addition, the review informed the development of my research questions and my choice of narrative inquiry as a methodology. The next chapter discusses narrative inquiry further and the methods used to explore midwifery practice during birth.
INTRODUCTION

My research aimed to explore midwifery practice during birth, and to understand the actions and interactions between midwives and women. I wanted to understand what midwives do during birth, and why they do what they do. I also wanted to understand how women experience midwifery practice, and how it influences their birth experience. My intention was to investigate the experience of midwifery practice from the perspective of the midwife, and of the birthing woman. Narrative is the linguistic form of experience, and stories can provide a context for understanding actions (Polkinghorne 1995). In narrative research, experience is the focus of study (Clandinin & Connelly 2000; Pinnegar & Daynes 2007). A narrative research approach also facilitates an exploration of the assumptions and norms of the individual and their cultural group, because stories convey these along with events (Ólafsdóttir & Kirkham 2009). Narrative researchers gather stories and seek the meanings in those stories (Ospina & Dodge 2005). Narrative inquiry was an appropriate methodology with which to investigate the research questions in my study. Memories conveyed as stories retain the complexity of the situation in which the action took place, and retain the emotional and motivational meanings associated with it (Polkinghorne 1995). When women shared their birth stories they revealed not only events, but also how they experienced midwives’ actions. In their stories midwives revealed their motivations for actions, and placed such actions within the context of an actual birth experience.

A feminist approach was taken throughout the research process. Feminist research places the participants at the centre of the inquiry, contributing directly to the generation of knowledge (Barnes 1999). Narrative inquiry is aligned with this approach because the participant, and their interpretation of their experience is central (Clandinin & Connelly 2000). In feminist research, methods used to
gain knowledge should be non-exploitative and respectful of the participants and their contribution (Acker, Barry & Esseveld 1991); and the primacy of women’s experience must be a key value (Walsh 2004). This involves listening to, and valuing women’s voices and their versions of events. It requires an awareness of power relations between the researcher and participants, and an attempt to reduce any controlling elements (Donovan 2006). Feminist research should also acknowledge the subjective involvement of the researcher, challenging the concept of ‘objectivity’ and valuing reflexivity and emotion as part of the research process (Letherby 2003). In addition, feminist research aims to be emancipatory, empowering women through the process.

This chapter asserts the importance of stories for women, midwives and mothers. It discusses the theoretical underpinnings of narrative inquiry as a research methodology. It then goes on to discuss the methods used to explore midwifery practice during birth.

**WOMEN, MIDWIVES, MOTHERS AND STORYTELLING**

For thousands of years humans throughout the world have shared stories (Clandinin & Rosiek 2007; Geanellos 1996; Koch 1998). Roof (1993, p. 298) describes humans as ‘story-telling animals’ and argues that stories illustrate and affirm who we are, providing identity, purpose and meaning to our lives. We tell others about our experiences using language to shape and transform our lived experience into stories (Holloway & Freshwater 2007). The stories we tell convey our identities, fears, hopes, cultural standards and describe our ‘lived time’ (Bruner 1985; Leight 2002; Yoder-Wise 2003). By telling stories we are able to bring order and direction to our experiences and our lives (Roof 1993). Carolan (2006, p. 5) argues that stories are ‘the principal means by which individuals make sense of their experiences.’ For the listener or reader, stories provide an effective method of transferring information as they capture the interest and are told in a familiar structure (Holloway & Freshwater 2007). Stories and storytelling are deeply embedded in the historical culture of midwifery and of women’s ways of sharing knowledge (Belenky et al. 1986; Donnison 1988). Ölafsdóttir & Kirkham (2009) suggest that it is difficult to access practical or traditional knowledge and find an appropriate scientific way to uncover it. However, it can be argued that a narrative approach to research facilitates access to midwifery and women’s knowledge.
Women and storytelling

A narrative approach to research has been used in the feminist movement (Gluck & Patai 1991). Fontana and Prokos (2007) maintain that in a culture that had traditionally involved masculine interpretation, narrative was seen as a way of understanding and valuing the history of women. Leight (2002) suggests that interviewing women can be seen as an opportunity for women to ‘tell their story’, and in narrative research this is taken further because their story is the centre of the interview. Encouraging participants to share their story validates their experience (Cotterill & Letherby 1993). Some feminists argue that knowledge sharing through storytelling is part of a female gendered epistemology (Belenky et al. 1986; Estes 1992), and embracing this epistemology can also contribute to political and social change. For example, Pinnegar & Daynes (2007) describe how personal stories became the rhetorical basis for grassroots movements in women’s consciousness raising groups in the United States. One of the roles stories played was to enable people without ‘expertise’ to contribute to the intellectual work of the movement. The stories also provided evidence of the need for political and social change. It is therefore not surprising that feminist researchers have employed narrative methodologies in their study of female experiences (Hall, Stevens & Meleis 1992; Stevens 1993).

Midwives and storytelling

Historically, birth knowledge was shared orally from woman to woman and maintained via the ‘collective culture of women’ (Donnison 1988). The knowledge and skills required to practice midwifery were gained through experience, and the sharing of experience through storytelling (Davis 2004). However, in the late sixteenth century the work of Descartes led to the development of a new masculine and mechanistic philosophy (Wickham 2004). This new system of knowledge rejected subjective ancient wisdom in favour of science and rationality. The universe was conceptualised as a huge machine governed by laws which could be understood through reason. The human body was also considered in terms of a machine, and childbirth was described as a mechanical process. Women were no longer what Wickham (2004) refers to as ‘legitimate knowers’, and a patriarchal authoritative knowledge was established that placed little value on women or their knowledge. As a result, interpretive knowledge and storytelling were considered to be unscientific, and therefore not valued. As the
education of midwives became formalised, the traditional ways of knowing were displaced and a scientific and objectivist approach to knowledge underpinned midwifery curricula (Donnison 1988).

However midwives have continued to informally share knowledge by telling birth stories, and these birth stories often become evidence on which practice is based (Leamon 2009; Wickham 2004). Midwifery culture is generated and sustained by storytelling in which beliefs, identities and relationships are linked to the narrative in addition to events and actions (Ólafsdóttir & Kirkham 2009). Story sharing appears to underpin knowledge building and exploration of practice. McHugh (1999, p. 3) notes, ‘get a group of midwives together and they start to share stories.’ Leonard’s (2008, p. 85) description of her experience at a midwifery conference will be familiar to many midwives:

The workshops are informative and educational, but the real event is the storytelling that goes on everywhere until the wee hours of the dawn... We sit hunkered in hallways, squatting in doorways, lying on beds in clusters of enthusiastically gesturing women, exchanging story after story. This is where the real teaching occurs. We are thirsty for all the powerful knowledge we can finally exchange with our peers.

Roncalli (1997, p. 178) also describes how sharing stories is central to midwifery knowledge:

One midwife will tell a story and the group listens intently, perhaps interrupting with questions... to an outsider these questions might seem like farfetched non sequiturs; to the midwives, each one telegraphs or occasionally opens up worlds of meaning and connection. Once the story is told, the group works it like a many-woman quilt. Each one brings her own scraps of experience, her own insight, derived from keen observation and undomesticated reflection, into how things are connected in a life, in a woman, and in a birth. The collective intelligence in such a session is staggering.

In recent years there has been a move to re-establish narrative methods in formal midwifery curricula (Brook & Barnes 2001; McHugh 2007 Leamon 2009). Leamon
(2004a) suggests that sharing stories about birth assists personal and professional development for students and qualified midwives.

Mothers and storytelling

Mothers throughout history have learned about birth by sharing stories. Traditionally, listening to the reflections of those who had already ‘been there’ prepared women for their own birth experience (Davis 2004). Today mothers continue to share birth stories verbally, in writing, and more recently via the Internet (Coates 2007; McHugh 2007). Women not only learn practical information about pregnancy, birth and mothering through exchanging stories, they also gain emotional and social support (Carolan 2005; Farley & Widman 2001; Savage 2001). Dahlen et al. (2008) found that the birth stories pregnant women hear from other women, in particular their mothers and sisters have a significant impact on their approach to birth. Callister (2004) carried out a study exploring the benefits of sharing birth stories for mothers. She found that mothers were keen to share their birth experiences, to rehearse the details, and to define their meaning. In addition, through sharing stories women created a sense of connection to other mothers and to the ‘universal nature of birthing’. She goes on to conclude that the opportunity to share birth stories is an important intervention in maternity care. Leamon (2004a, p. 15) also maintains that encouraging the telling of birth stories is an important aspect of midwifery practice because ‘listening and attending to women is a fundamental part of what we do as midwives.’

Birth stories in research

Ólafsdóttir and Kirkham (2009) argue that the midwifery profession needs to develop its own body of knowledge by examining birth stories to provide a context for understanding what midwifery is. This understanding could be used to identify epistemologies that underpin midwifery practice and produce knowledge that has the ability to influence maternity care. Birth stories have already become a focus of midwifery research. Carolan (2006) conducted a literature review of the use of birth stories as evidence and identified three broad categories. My own approach fits into the first two categories.

The first category of evidence involves women’s birth stories being analysed as data with an aim of revealing women’s experiences of pregnancy and birth.
Researchers have used this approach to examine a range of experiences associated with pregnancy, birth and mothering (Callister & Vega 1998; Callister et al. 2003; Cheyney 1992; Coffman 1998; DiMatteo, Kahn & Berry 1993; Lee 2002; Miller 2009; Nyström & Axelsson 2002; Schaefer 2004; Simpkin 1991; Simpkin 1992; Thornburg 2002; Trulsson & Rådestad 2004; VandeVusse 1999; Van Riper 2005). I used this approach to explore women’s experience of midwifery practice during birth. The second category includes stories from midwives and student midwives that illustrate a particular case. In the case of my study, care during an uncomplicated birth was the particular case. Previously researchers have analysed midwives’ stories to explore a range of specific issues such as providing support to parents during pregnancy (Hildingsson & Häggström 1999); attending stillbirths (Browne 2003); or midwives’ interpretation of pain in labour (Vague 2003). Thorstensson, Nissen and Ekström (2007) analysed written narratives to explore student midwives’ experiences of offering continuous labour support to women/couples. The third category of evidence is mostly aimed at childbearing women and consists of verbatim birth stories which are published without interpretation.

Valuing stories in research methodologies is consistent with the midwifery culture of learning, and with the woman centred philosophy of midwifery. However, story-based research comprised a very small proportion of Carolan’s (2006) review. She concludes that a greater emphasis needs to be placed on women’s stories as data in research. In addition, there are limited studies which involve both midwives’ and mothers’ perspective on a particular issue. One study by Kennedy et al. (2004) included both perspectives as part of a larger Delphi study. They used narrative analysis to interpret the stories of 14 midwives and four women they had provided midwifery care to. This study illustrated midwifery practice and explored women’s experience of midwifery care. My study involved both midwives and mothers, but the intention was not that participants would have shared experiences of the same birth.

**NARRATIVE INQUIRY**

Story sharing is culturally embedded within midwifery, therefore narrative inquiry is a particularly relevant methodology for the study of midwifery practice during birth. Polkinghorne (1995, p. 5) describes narrative inquiry as a 'subset of qualitative research designs in which stories are used to describe human action'.
Whilst stories are central to narrative research, there is no clear methodological structure that defines the approach. However, regardless of the specific methodological approach taken, the treatment of stories as a rich source of data is central to narrative research (Emden 1998a; 1998b). Pinnegar and Daynes (2007, pp. 4-5) maintain that narrative researchers consider the story to be ‘one of, if not the fundamental unit that accounts for human experience’ and that ‘narrative inquiry begins in experience as expressed in lived and told stories.’ Howie (2010a) suggests that stories reveal the complexities of human activity, and these stories can enhance our understanding of people in their environments. My study aimed to reveal the complexities of midwifery practice during birth and to enhance understanding of midwives in their working environment. Essentially, I aimed to tell a narrative of midwifery practice during birth from the perspective of the mothers’ and midwives’ in my study.

**The narrative turn**

In recent decades there has been an increased interest in narrative within human science and research practice. This phenomenon has been described as the narrative ‘turn’ or ‘boom’ or even ‘explosion’ (Hänninen 2004). Pinnegar and Daynes (2007) describe four intertwined themes in the turn towards narrative inquiry as a research methodology. The first turn was a change in the relationship between the research and the researched. This involved a move away from the positivist perspective towards a perspective focussed on interpretation and understanding meaning in which both researcher and researched learn and change in the process. The second turn was from numbers to words as data. This involved recognition that the nuances of experience and relationship can become lost in numeric codes. The third turn was from the general to the particular. The value of a particular experience, in a particular setting, involving particular people was understood. The fourth turn was ‘blurring knowing’. This required an understanding that there are multiple ways of knowing and understanding human experience. The development of narrative research has also been influenced by the emancipation efforts of marginalised groups (Riessman 2008). Narrative inquiry provides an opportunity for the stories of oppressed groups and individuals to be heard, for example in it’s use in the feminist movement (Fontana & Prokos 2007; Gluck & Patai 1991)
The ‘narrative turn’ has been embraced by many disciplines including anthropology, sociology, law and history (Riessman 2008). It can be argued that the move towards narrative research is particularly relevant to health care professionals. Qualitative health research often examines people's experiences of events such as treatment, disability or birth. Some qualitative approaches such as phenomenology focus on the experience itself (Liamputtong 2009). Narrative research does not attempt to describe an experience; instead it focuses on the re-presentation of experience through people's reflections and stories about experience (Clandinin 2007). The recognition of narratives as a rich data source has led to researchers using narrative methodologies to examine health related areas, including women's health (Riessman 2003; Riley & Hawe 2005; Sandelowski 1991; Stevens 1993; VandeVusse 1999).

Defining narrative inquiry

The boundaries of narrative research are rather unclear. An examination of the literature reveals a diversity of terms, definitions and descriptions regarding what narrative methodology comprises. The conflicts, diversities and complexities surrounding narrative research have been noted and discussed within the literature (Clandinin & Rosiek 2007; Clandinin 2007; Czarniawska 2004; Holloway & Freshwater 2007; Howie 2010a). Squire, Andrews and Tamboukou (2008, p. 32) suggest that 'unlike other qualitative research perspectives, narrative research offers no overall rules about suitable materials or modes of investigation, or the best level at which to study stories.’ These unclear boundaries have resulted in a wide range of narrative research studies using a wide range of data and methods of analysis; from the creation of stories from data (Emden 1998a) to the quantitative analysis of narratives (Franzosi 2010).

There are two main types of narrative inquiry, although the terms used to refer to them vary. Polkinghorne (1995) was the first to identify and describe the two types, which are based on Bruner's (1985) distinction of two modes of thought, paradigmatic and narrative. The first type is 'analysis of narratives' whereby the researcher collects stories as data and analyses them using a paradigmatic process. The result is descriptions of themes that are evident across the stories, or in taxonomies of types of stories, characters or settings. The second type is 'narrative analysis' whereby the researcher collects descriptions of events and uses a plot to synthesize or configure them into a story, such as a case study or
biographic episode. Polkinghorne (1995) summarises the differences between the two types of narrative inquiry as ‘analysis of narratives’ moves from stories to common elements, whereas ‘narrative analysis’ moves from elements to stories. The type of narrative inquiry used for my study was ‘analysis of narratives’ because I was interested in the motivations and intentions behind midwives actions, and how women experience those actions. Essentially, I was looking for a common ‘narrative’ of midwifery practice during birth, the similarities between individual storied experiences. Whilst there are many ways to conduct narrative inquiry there are many corresponding ideas about what narrative research is (Howie 2010a). Elliot (2005, p. 6) identified some common themes associated with narrative research which include:

...an interest in people’s lived experiences and an appreciation of the temporal nature of that experience; a desire to empower research participants and allow them to contribute to determining what are the most salient themes in an area of research; an interest in process and change over time; an interest in the self and representations of the self; an awareness that the researcher himself or herself is also a narrator.

**Constructing meaning**

The epistemology underpinning my research approach is constructionism (Crotty 2003). The constructionist understanding of knowledge differs from the alternative objectivist epistemology. Objectivism considers that an objective truth already exists, and that people discover this fixed truth. Objectivist principles are often associated with quantitative research whereby the aim is prediction and control of phenomena. On the other hand, constructionism views truth and meaning as constructed by the person through their engagement with the phenomenon. It is this epistemological paradigm that provides the foundation for many qualitative studies, including this one. The epistemology of constructionism is closely aligned with narrative inquiry. Individuals are active in the construction of reality rather than passive receivers of reality (Holloway & Freshwater 2007). They build their perspectives and perceptions of reality within the context of their history, locality and culture. Context and interaction with context is required for
the construction of meaning, and meaning is shaped by interaction and language (Clandinin & Connelly 2000).

Narratives are used to construct, and make sense of events, and of our lives (Bruner 1987). We use stories to retrospectively create meaning and understand the events that make up our lives, and to share those events with others. Kielhofner (2008 p. 110) maintains that as humans we ‘draw meaning from life by locating ourselves in unfolding narratives that integrate our past, present, and future selves.’ In addition, people create their own narrative identity through telling stories about themselves (Sparkes 2004). Whilst stories may be concerned with an individual’s experience, the telling and the construction of meaning through sharing is social in nature because story generation and telling is interactive. In relation to birth stories, Leamon (2009) argues that within a woman’s story lies a complex combination involving her life, the event, her thoughts and feelings and the language she chooses to use in its communication. Squire, Andrews and Tamboukou (2008) suggest that narrative research must address structure and context because the meanings are embedded in these. Atkinson (1997, p. 341) warns that it cannot be assumed that narratives of personal experience provide unique access to a ‘realm of hyperauthenticity’. Instead, researchers need to recognize that experience, memory and biography are constituted through the act of storytelling. Narratives are shaped and have form and function, researchers must pay attention to both what is being said and how the story is being constructed (Atkinson 2010). Atkinson (1997, p. 335) also asserts that narrative research can be misused, becoming what he refers to as ‘a surrogate form of liberal humanism and a romantic celebration of the individual subject.’ However, he maintains narrative remains valuable as a qualitative research approach amongst other approaches.

**Stories and narratives**

Narrative research involves the study of narratives or stories, and the terms ‘narrative’ and ‘story’ are another area of inconsistency within the literature. The word ‘narrative’ derives from the Latin word ‘gnarus’ which means knowing (Holloway and Freshwater 2007). Whereas the word ‘story’ derives from the Greek and Latin word ‘historia’ which also means knowing (by inquiry) in addition to referring to an account of events. Some researchers consider the terms ‘narrative’ and ‘story’ to have distinct meanings (Riley & Hawe 2005). For
example, Frank (1995, 2000) uses the term ‘story’ to refer to the tales people tell, and ‘narrative’ when referring to general structures encompassing a number of particular stories. Narratives are considered to be units of analysis that arise from stories. Emden (1998a, p. 35) defines a narrative as the collective ‘stored wisdom’ of peoples’ individual stories, which is aligned with Frank’s definition.

However, other researchers use the terms ‘narrative’ and ‘story’ interchangeably (Holloway & Freshwater 2007; Liamputtong 2009; Riessman 2008). My own use of the terms is interchangeable; I use the words ‘narratives’ and ‘stories’ synonymously to refer to personal accounts of experiences and the meanings assigned to them by the teller (Holloway & Freshwater 2007). This approach is aligned with Polkinghorne’s (1988) use of the term ‘narratives’ to refer to the unique stories of individuals which reveal their personal experiences, actions and interpretations. Narratives (or stories) consist of lengthy accounts and reflections of the narrator (storyteller) which are distinct in content and plot. In this case, personal accounts and reflections of birth and midwifery practice during birth. I also use the term ‘narrative’ to refer to the holistic form of the combined individual narratives. For example, in referring to the narrative of midwifery practice during birth, I am referring to the commonalities and themes arising across the individual narratives.

Elliot (2005) identified key features of narratives: they are chronological and represent a sequence of events; they are meaningful; and they are inherently social. It can be argued that chronology is not necessarily a feature of all narratives, as storytellers will often jump forward and backward in time whilst conveying an event. For example, when they remember something about a previous part of the story. Greenhalgh and Hurwitz (1998) identified that narratives have a finite time sequence, which may better explain the aspect of time in narrative. Whilst the telling of the story may not be chronological, the narrative is about a particular time sequence. Greenhalgh and Hurwitz (1998) also identified that narratives have a narrator; are linked to the individual; are based on the subjective experience of the storyteller; and are capable of holding the audience’s interest. The term ‘plot’ is commonly used in relation to narratives and narrative inquiry. Polkinghorne (1995, p. 5) describes ‘plot’ as ‘a discourse form in which events and happenings are configured into temporal unity by means of a ‘plot’’. A plot enables connection between the past, present and future to become evident (Berger & Quinney 2005). It also allows the specific events to
be brought into a meaningful whole (Polkinghorne 1988). For example, the action of a midwife listening to the fetal heart rate at a particular time during labour is a specific event. The plot would include the context of the action, the meaning of the action, how the labouring woman experienced the action, and other actions that occurred.

The ‘storytelling relation’, influences what is told, how it is told, and how it is interpreted (Frank 2000). The storytelling relation includes the relationship between the narrator and the listener, where the story is told, and the reason the story is told. For example, a midwife telling another midwife a birth story may use different language, focus on different elements, and include different events; than a midwife telling a pregnant woman a birth story. Leamon (2009) argues that the ‘listener’ influences not only how the story is told, but also how it is received and interpreted. How the listener engages with the story, the characters and plot; and how it relates to them and their life, is integral to the way the story is received and interpreted. For example, a pregnant woman is likely to receive and interpret a birth story in a different way than a midwife would. Therefore, the story and its meaning are co-constructed by both the teller and the listener. In narrative research, the researcher must be reflexive about this process (Josselson 2007). Clandinin and Connelly (2000) conceptualise a three-dimensional narrative inquiry space based on Dewey’s theory of experience. One dimension is ‘temporality’ (the past present and future); another dimension is the ‘personal and social’ (interaction); a third dimension is ‘place’ (situation). They argue that narrative inquiry is defined by this three-dimensional space and researchers must consider each dimension. Approaching narrative inquiry in this way allows a deeper understanding of individual stories and how they relate to the social.

For the purposes of my study a narrative analysis approach was taken with the intent of identifying similarities between participants’ stories, and identifying the narrative of midwifery practice during birth (Polkinghorne 1995). My attention was focussed on not only the specific events being conveyed by a story, but also on the plot in which events were embedded (Berger & Quinney 2005; Polkinghorne 1988). Reflexivity was employed to examine the ‘storytelling relation’ and how it influenced the construction and interpretation of narratives (Frank 2000; Josselson 2007; Leamon 2009). The remainder of this chapter outlines the methods used in undertaking the narrative inquiry.
METHODS

Ethical considerations

Ethical clearance was granted for the study by the University of the Sunshine Coast Human Research Ethics Committee prior to data collection. The application was later amended to allow the inclusion of one participant, whose baby was 14 months old, therefore outside the inclusion criteria. Documents relating to ethical clearance and participant documents are available in the appendix of this thesis (Appendices A-G). During the conduct of the research no adverse incidences occurred that required reporting to the ethical committee. The National and Medical Research Council (Australian Government 2007) values and principles were adhered to throughout the research process. Some ethical challenges arose during the research process and they are discussed within the relevant subheading below.

Finding storytellers: sampling and recruitment

Purposive sampling was used to ensure that participants would have experience relevant to the study. Purposive sampling allows the researcher to establish inclusion and exclusion criteria in order to capture participants with specific qualities (Guest, Bunce & Johnson 2006). Patton (2002, p. 230) refers to purposive sampling as a means of accessing ‘information-rich cases’. I wanted to interview mothers who had experienced an uncomplicated vaginal birth with midwifery care, and midwives who had attended an uncomplicated vaginal birth as the main carer. Recruitment of participants began by distributing invitations to participate. For midwives invites were handed out at midwifery workshops and meetings. Invitations for mothers were handed out at community groups attended by new mothers. I intentionally did not recruit via hospitals or organisations because I wanted to capture midwives working in a range of settings, and women who had birthed in a variety of settings. As recruitment continued snowball sampling began to occur (Liamputtong 2009). Mothers and midwives who participated in the study went on to distribute invitations amongst friends and colleagues. In addition, recruitment occurred via word of mouth with participants contacting me because they had heard I was doing research. Recruitment and interviewing took place over a one year period.
I conducted a single interview with each of the 20 participants. The initial aim was to interview 10 midwives and 10 women, but to continue beyond this if theoretical saturation did not occur (Llewellyn, Sullivan & Minichello 2004). According to van Teijlingen and Ireland (2003), purposive sampling involves continued recruitment and interviewing until no further themes arise. This requires ongoing analysis to recognise emerging themes and identify when saturation is reached. Theoretical saturation occurred in my study around half way through the recruitment and interviewing period. Guest, Bunce and Johnson (2006) noted there was little guidance in the literature regarding how many interviews are generally needed to reach saturation. Therefore, they conducted research to find out how many interviews needed to be carried out before ‘thematic exhaustion’ was reached. They used data from a study involving 60 in-depth interviews and systematically documented the degree of data saturation and variability over the course of thematic analysis. They found that the major themes were evident within the first six interviews and saturation occurred within 12 interviews. These findings are consistent with my experience, and the final interviews I conducted allowed me to verify themes rather than identify new ones.

In total I interviewed 10 midwives and 10 mothers, as initially planned. However, one of the midwives (Gina) had recently given birth and also shared her birth story during her interview as a ‘midwife’; increasing the number of birth stories from a mother’s perspective to 11. The sample of mothers included five who had more than one baby and birth experience (six including the midwife). Therefore, the 10 mothers interviewed in the study shared 18 birth stories in total as part of their ‘birth story’. The 10 midwives also included reflections on other birth experiences in addition to the ‘birth story’ they told, increasing the overall number of birth stories told. All of the participants lived and worked in South East Queensland at the time of the interviews.

**Gathering stories: in-depth interviews**

I used single, face-to-face, in-depth interviews to gather stories for analysis. Although written stories are used in narrative research, interviews appear to be the most common method of gathering stories (Polkinghorne 1995). Face-to-face interviews allow the researcher to pick up on the latent content of the story through gestures, facial expressions and body language (Sullivan 1998). Interviews also offer the advantage of being able to immediately gain detail and
clarification of interpretations if necessary (Liamputong & Ezzy 2005; van Teijlingen & Ireland 2003). For participants, recounting a story verbally is less time consuming and requires less effort than a written account. Interviewing also allows the inclusion of individuals who are unable or unwilling to write out their story (Sullivan 1998). Asking participants to tell their story may result in a more holistic account of the event in comparison to the fragmented answers which may be given when specific questions are asked (Holloway & Freshwater 2007).

Sandelowski (1991) suggests that during a traditional interview the relationship between the researcher and participant is often unbalanced with the researcher being dominant and directing the interview with questions. In keeping with a feminist perspective, a storytelling approach aims to rebalance the power relationship between researcher and participant. It allows the participant to control the content of their story rather than answering the researchers questions. Another advantage of the narrative approach to interviewing is that it is a familiar concept for participants. Telling stories is part of human nature and people have a natural desire to share their experiences through stories (Holloway & Freshwater 2007). The birth story is a culturally accepted and understood format for sharing the birth experience amongst women (Coates 2007; McHugh 2007; Savage 2001). As discussed above, sharing birth stories is also a familiar form of learning for midwives (Geanellos 1996; McHugh 2007; Wickham 2004). Therefore, the story-telling format of the research interview was familiar and comfortable for both women and midwives.

There also appear to be benefits for participants in sharing their story with a researcher. In Callister’s (2004) study she found that participants welcomed the opportunity to make meaning of their experience by sharing their birth stories. One participant commented that ‘women everywhere just have to tell their birth stories’ (p. 510). McHugh (2007) argues that for women, telling their birth story provides an opportunity to reaffirm their identity and sense of self. Participants in my study, in particular the mothers often thanked me after their interview. Initially this was rather surprising to me as I was extremely grateful for their participation and the sacrifice of their valuable time. However, it became apparent that there were reciprocal benefits for both the participants and myself in the exchange of a birth story. At the end of her interview Belinda (a mother) stated ‘I haven’t had the opportunity to do that [share the birth story], so it’s good for me too.’ For some mothers sharing their story appeared to be cathartic and helped them to voice
difficult experiences they had been unable to express to others. Midwives in the study also used the interview to express frustrations and reflect on their practice.

**Listening to birth stories**

Interviews were conducted at a time, and in a setting chosen by the participants. All of the mothers in the study chose to be interviewed in their home, or in one case at her sister’s home. One midwife came to my home to be interviewed, two midwives came to the university to be interviewed, and one midwife chose to be interviewed at her workplace. The length of interviews varied from 20 minutes to 90 minutes, with most lasting around 60 minutes. Callister (2004) devised guidelines for interviewing new mothers about their birth (see Appendix H). Although these guidelines were aimed at clinical settings, I used them as a reference for my own interviews with women.

I set out to conduct a conversational and in-depth interview triggered by a story. I found that each participant group required a slightly different approach. Like previous midwifery researchers, I was aware that my experiences and philosophy as a midwife provided a basis for my approach as an interviewer (Hunter 2007; Leamon 2004; Leamon 2009). I focused on listening and attending rather than asking or directing. Josselson (2007, p. 547) stated that ‘we listen people into speech’, and this seemed particularly true in my interviews with mothers. I found that I needed to say very little, if anything, during mothers storytelling. Callister (2004) also found that the mothers in her study needed little encouragement to talk about their birth experience. In addition, mothers were able to remember in great detail their birth experiences. This is consistent with Simpkin’s (1992) study that found women were able to retain vivid and accurate memories for many years after their birth. In contrast, the midwives often required more prompting and questioning, and would also readily engage me in conversation with their own questioning. Whilst midwives told their central birth story, they also shared other relevant birth stories and reflect on their practice outside of the central birth story. This conflicts with Emden’s (1998a) notion that narratives are chronological in nature.

Interviews were taped using a digital recorder. Taping the interviews allowed me to preserve the story as it was told with the words and inflections of the storyteller (Anderson & Jack 1991). I only experienced one recorder malfunction but I was able to use my phone to record the interview instead. Rubin and Rubin (2012)
suggest taking notes during interviews to record the main points and to back up the tape. However, I felt this would interfere with my interview approach and may distract participants. Instead, I immersed myself in the interview and immediately after leaving the participant’s home wrote notes in my research diary. The use of a research diary assisted reflexivity and ongoing reflection (Ballinger 2003). I recorded my thoughts and feelings about the interview content; my performance as interviewer; the participant; my relationship with the participant; and my biases and assumptions.

**Relationships and rapport**

Leamon (2009) suggests that the researcher-participant relationship should echo the midwife-mother relationship in that it is based on trust and respect. This foundation of a trusting and respectful relationship is also aligned to a feminist research approach (Oakley 1993). Establishing a rapport is essential in the development of the researcher-participant relationship (DiCicco-Bloom & Crabtree 2006; Hunter 2007). Josselson 2007 argues that ‘the greater the degree of rapport and trust, the greater the degree of self-revealing...’ Rapport involves trust and respect for the participant and the information they share, and the establishment of a safe and comfortable environment for sharing (DiCicco-Bloom & Crabtree 2006). In an article entitled ‘the art of teacup balancing’: reflections on conducting qualitative research’ Hunter (2007) describes how developing rapport begins before the interview with the emails and phone calls required to arrange a meeting. She notes that it is important not to rush into the interview but to establish a rapport first – again midwifery experience is useful here. My own midwifery practice in a hospital setting enabled me to develop the ability to establish rapport quickly with mothers and their families.

Self-disclosure can enhance rapport and is considered good research practice by some feminist researchers (Dickson-Swift et al. 2007). In her research Hunter (2007) felt it was important to give something of herself to participants since she was asking them to share themselves. Josselson (2007) also suggests that self-disclosure is ethical and rapport building. However, it must be acknowledged that self-disclosure could influence the researcher-participant relationship, the data collected, and ultimately the analysis (Dickson-Swift et al. 2007; Josselson 2007). Self-disclosure was almost unavoidable in my study because I have been a practising midwife in South East Queensland for a number of years, and the midwifery community is small. I had previously met a few of the mothers I
interviewed at community groups. All of the midwives had met me or worked at the same place as me at some point. This facilitated trust and rapport as we had experiences in common. Before interviewing mothers I explained that I was a midwife interested in women’s birth experiences, and how midwifery practice influenced birth experiences. I provided any further information in response to questions, although usually this introduction was enough. Occasionally I would be asked by mothers to clarify the name of a procedure or drug relevant to their birth experience. I was never asked for my opinion or interpretation of the stories I was told. I also did not get the sense that mothers were wary of sharing details about their experience of midwifery practice, or their opinions of maternity care despite knowing I was a midwife.

I noticed that the researcher-participant relationship between myself and the midwives in the study was different to the one between myself and the mothers. I did occasionally sense that midwives were a little wary of sharing details about their practice. Perhaps for fear of judgement (Rubin & Rubin 2012), or concern that I may disclose information. Therefore, I reiterated the confidentiality of the interview and that I was not judging their practice but wanted to understand their experience of providing midwifery care. I was also asked a few times about my own practice, or asked to provide an opinion on a practice. I felt it was unfair to expect disclosure of participants practice without being willing to do the same myself. Establishing a rapport requires a foundation of trust and respect in the researcher-participant relationship, which may require a degree of self-revealing (DiCicco-Bloom & Crabtree 2006; Hunter 2007; Josselson 2007). Therefore, I shared this information with them. Only one midwife revealed that she routinely carried out practices that could be considered unsafe. This resulted in an ethical dilemma for me as a researcher and a midwife. I dealt with this after the interview by engaging the participant in a friendly discussion via email about the ever-changing nature of midwifery practice and sent her current evidence.

**Challenging and interesting situations**

I encountered a few challenges and interesting situations during the process of collecting data. Interviewing mothers in their home inevitably involved the company of babies, toddlers, partners, other family members and pets. I considered that the woman’s family was more important than my interview, and I fitted around their needs. As a midwife I am used to working in the midst of family chaos. In some cases this involved many pauses in the interview whilst family
members were attended to. It was anticipated that participants may share painful and distressing experiences with me, and two of the mothers became visibly upset whilst telling their story. It is unethical to leave a participant distressed (Sullivan 1998), so for one participant I stayed for a while to assess her mood and offered to refer her for additional counselling if she felt she needed it (DiCicco-Bloom & Crabtree 2006). I also phoned her the following day to check she was OK, and she was. Other participants disclosed some distressing experiences without becoming outwardly upset. I felt that listening to their story may have validated their experiences by giving them the time to talk about them (Dickson-Swift et al. 2007).

According to Smith (1992 p. 102) ‘the role of the researcher is not to produce catharsis although it may be stimulated.’ The cathartic effect of the research interview is considered to be beneficial for many participants (Brannen 1993; Dickson-Swift et al. 2007; Squè 2000). In some cases this meant I listened to lengthy accounts of events that were not directly related to my research topic (eg. miscarriage). However, I felt that this was important, and a way I could ‘give something back’ to the participants. Patai (1991) identified that many people who participate in research do not have enough people in their lives who want to listen to what they have to say. This may raise questions about whether they chose to participate in order to be heard, and whether this is ethical. However, the complexities of why any participant offers to be interviewed are difficult to tease apart. Instead, I respected and valued all offers to participate and was happy to provide an interested ear for those that may have lacked this in their lives.

I assured all participants that I would maintain the anonymity of themselves and anyone they mentioned in their story. In a small ‘birth world’ this presented some challenges. For example, some midwives would directly ask me, ‘have you interviewed x?’ I would respond by telling them I was unable to tell them whom I had or had not interviewed. In some cases I knew the midwives in the women’s stories. I was asked by a couple of mothers whether I knew their midwife and I answered yes if I did, but did not share the nature of the relationship (eg. friend or colleague). Two of the mothers I interviewed shared birth stories involving midwives I also interviewed. However, the birth stories the midwives shared were not about those particular mothers. I also had one experience of bumping into a participant (a mother) at a community group where we had to pretend not to know each other when introduced.
DATA ANALYSIS

As previously discussed there are ‘numerous definitions and conceptualisations of narrative and narrative research’ (Holloway & Freshwater 2007, p. 80); and clear accounts of how to carry out data analysis are rare (Squire, Andrews & Tamboukou 2008). The type of narrative inquiry I carried out was the paradigmatic analysis of narrative. Polkinghorne (1995) describes two approaches to paradigmatic analysis. One in which concepts derived from previous theory are applied to the data to determine if particular concepts can be found. The second, used in this study, involves inductively deriving concepts from the data. In addition, Polkinghorne advises that paradigmatic analysis does not simply discover themes, but also identifies the relationships between themes. In my study I used thematic analysis to identify similarities and patterns occurring across the stories and indentified relationships between those themes. Data analysis was carried out alongside data collection and was interpretive. Interpretive data analysis aims to understand intention and action rather than just explain behaviour (Ospina & Dodge 2005).

Data management

The data management process consisted of four steps based on phases described by Fraser (2004) and Rowe (2003):

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<tr>
<th>Step</th>
<th>Rationale</th>
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<tbody>
<tr>
<td>1</td>
<td>Listen to the entire taped interview</td>
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<tr>
<td></td>
<td>Listening to entire recording may assist in taking in the whole narration and thinking in more lateral ways about the data.</td>
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<tr>
<td>2</td>
<td>Transcribe the interview (myself)</td>
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<td></td>
<td>Personally transcribing interviews enables the researcher to become closer to the stories.</td>
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<tr>
<td>3</td>
<td>Organise the transcript into a coherent story by removing incidental words and questions; using subheadings to signpost the narrative content</td>
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<tr>
<td></td>
<td>To create a clean and coherent story for analysis. Personal narratives often contain overlapping and chaotic utterances. The focus of analysis is on what is said rather than when and how it is said.</td>
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<tr>
<td>4</td>
<td>Analyse stories to identify commonalities and distinctions across the individual stories.</td>
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<tr>
<td></td>
<td>To discover and explore emerging themes.</td>
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I transcribed the recorded interviews myself to maximise my exposure to the data (Sullivan 1998). Transcription took place as soon as possible after the interview, usually starting within a few days. This made it more likely that I would remember non-verbal details of the interview (van Teijlingen & Ireland 2003). I listened to the interview first to get a sense of the whole narrative. I then transcribed the entire interview, recording any thoughts or questions that arose in my research diary. I was also able to reflect on my interview technique whilst transcribing. Roulston, deMarrais and Lewis (2003) carried out research exploring students’ experiences of interviewing and transcribing and one participant described transcribing as ‘lonely and tiring’ (p. 657). This was also my experience, but I also found it an invaluable part of the research process which contributed greatly to the ongoing data analysis.

De-identification of participants and others mentioned during the interview happened at transcription. After their interview participants were invited to choose a pseudonym for themselves and this name was used on all documentation. Only ‘consent to participate’ forms contained real names and contact details. These forms were kept in a locked filing cabinet, which only I had access to. Any references made to places that could lead to identification of participants were also removed during transcription. It is important to not only protect participants themselves, but also the people and organisations they mention in their interview (Josselson 2007). Therefore, names and places were removed during transcription. Recordings of interviews will be destroyed five years following publication of this thesis as per the ‘university sector retention and disposal schedule’ (Queensland State Archives 2009).

After transcribing an interview I then listened to the recording whilst reading through the transcript. This allowed me to ensure that the written narrative matched the spoken narrative, and retained the intent and emphasis of the participant (DiCicco-Bloom & Crabtree 2006; McLellan, MacQueen & Neidig 2003). I then emailed the transcript to the participant asking them to edit and/or comment if they wished. This also allowed participants to check that their story had been captured accurately. Only one participant requested the deletion of some content because she felt her comments could lead to the identification of a particular person. Participants, in particular mothers seemed to appreciate getting a copy of their transcription, and some indicated that they would use the transcription as a basis for writing their birth story. For example in an email one wrote: ‘That is great thank you so much for all your efforts, it is lovely to have that
transcript for my records too.’ Other participants remarked on how nice it was to read their story. I was pleased that I could give something back to participants in gratitude of their input to my study.

Once a participant had confirmed that they were happy with their transcript I organised it into a coherent story. This involved removing incidental words and questions such as exchanges about a crying baby or other ‘small talk’ and off topic discussion. I then used subheadings to signpost the narrative content, for example ‘the beginning of labour’. For mothers this usually consisted of chronological signposting from pregnancy to after the birth, and then reflections on the birth. For midwives this was more difficult because they often jumped from one birth story into another. In addition, after telling their story we often discussed midwifery practice in general. Therefore subheadings included midwifery practices such as ‘listening to the fetal heart’.

NVivo software was used to organise the data and to begin identifying themes. This software allowed me to create nodes for emerging themes and to easily cut, paste and move quotes into nodes. NVivo is a tool for organising data, it cannot decide how to code, or what questions to ask of the data (Bazeley 2007). Richards (2009) identifies two types of coding; topic coding and analytical coding. I used topic coding to allocate data to topics, for example ‘pushing’. Analytical coding involved considering meanings in context by focusing on an expression, word or phrase that reoccurred in the data, for example ‘in the zone’. Richards (2009) warns that using software for coding can increase the risk of the researcher creating too many categories or themes. I did begin to become overwhelmed with nodes and felt that the fragmented data began to distance me from the narratives themselves.

**Thematic analysis**

Although NVivo facilitated the identification of some early themes, my next step was to return to the whole narratives again. I re-read each narrative, writing notes and highlighting sections. This allowed me to get close to the individual stories again, and to see if themes remained consistent when considered in relation to whole narratives. Once I had re-read all of the narratives I began moving between them, comparing and identifying commonalities and differences. I became totally immersed in the data, and knew each story intimately. I felt I understood the meanings held in the data but struggled to anchor this to an
explanatory framework. In times of frustration my supervisors reassured me that ‘the data would speak’ to me. I wondered when and how this would happen as I read and re-read narratives, notes and literature. I found I had my biggest breakthroughs when I was not trying. For example, on a number of occasions I would wake in the early hours of the morning with an insight. I would draw or write down this insight and then go back to the data with it. Richards (2009) suggests that qualitative researchers often spontaneously draw models of what is emerging from data, and I created a number of visual representations of my findings as I worked through the analysis process. Visual models were also an effective way of communicating findings with my supervisors.

Borland, Gluck and Patai (1991) argue that the issue of ‘interpretive authority’ can be problematic for feminist researchers because it involves a contradiction. The researcher must find a balance between presenting their work in a way that respects the participant’s story and interpretation, whilst also taking responsibility for providing their own interpretation of her experience. Mitchell and Salmon (1999) suggest that midwifery research should involve childbearing women in the entire research process from conception to analysis. Some feminist researchers also advocate the involvement of participants in the analysis process (Borland, Gluck & Patai 1991). The rationale for this involvement is an attempt to redress the researcher-participant power imbalance. It challenges the authority of the researcher as the expert and allows participants to control the findings. However, I decided against this collaborative approach to analysis in my study for a number of reasons. On a practical level I felt it was unfair to expect busy mothers and midwives to spend time analysing data for a study that was driven by my interests and questions. It can be argued that to do so could be considered exploitative. In addition Smythe & Murray (2000) argue that it is the duty of the researcher to relate the meanings of a participant’s story to the theoretically significant wider picture. This may contrast with the participant’s specific concerns about their own personal story. I was looking for similarities across the data, and this would be difficult to do collaboratively without participants also having to consider other participants stories. Therefore, the ownership of the narrative transferred to myself, the researcher for the purposes of analysis (Josselson 2007).

With the responsibility of analysis came the responsibility to ensure I maintained reflexivity throughout. It was important not to misinterpret the data based on my own assumptions (Holloway and Freshwater 2007). I employed a number of strategies to facilitate reflexivity and ensure themes were evident in the data and
not just arising from my experiences and beliefs. I reflected upon my assumptions
and biases in my research journal and with my supervisors. I sought out
competing conclusions and interpretations of what I was finding within the data
(Malterud 2001). I checked my interpretations with my supervisors sharing
narratives and quotes from narratives with them, which enhanced rigour.

Rigour

There is some debate and contradiction within the literature regarding the criteria
and terminology for assessing the quality of qualitative research (Twycross &
Shields 2005). When considering the quality of my research I referred to two
sources in particular. The first is an article written by Shank and Villella (2004)
discussing a review of qualitative research articles. They argue that qualitative
research requires a new breed of evaluative criteria, that simply re-defining
criterion from quantitative research does not reflect the different aims of
qualitative research. They liken quantitative research to the metaphor of a
window, used for a clear and transparent look at things. This requires the
research to be clear and transparent, and issues such as reliability, validity, bias
and generalisability are significant. However, qualitative research is likened to a
lantern, used to illuminate dark areas. By shedding light on hidden things we can
begin to understand them. In their article they suggest four new evaluative criteria
for qualitative researchers: investigative depth; interpretive adequacy; illuminative
fertility; and participatory accountability. Investigative depth requires the
researcher to go below the surface and discover something new. Research has
‘interpretive adequacy’ when it provides ‘a richer, more complex, yet
understandable picture of the area under study’ (Shank & Villella 2004 p. 50).
‘Illuminative fertility’ involves changing the current theoretical view of a topic, or
changing practices. ‘Participatory accountability’ necessitates that researchers
‘operate in an ethical manner and to ensure that readers understand their
actions, stances, and efforts’ (Shank & Villella 2004 p. 51).

My own study demonstrates these four evaluative criteria in the following ways.
The research process was conducted in an ethical manner, and the process is
presented in this chapter to the reader (participatory accountability). My analysis
moved beyond the experiences and descriptions provided in the individual
narratives. An explanatory framework was applied to more deeply understand
and communicate the narrative of midwifery practice in a novel way (investigative
depth and interpretive adequacy). The final thesis offers a new and different
theoretical perspective on the topic, and has generated recommendations for changes to midwifery practice and further research (illuminative fertility).

In addition to Shank and Villella’s (2004) evaluative criteria I used Walsh and Downe’s (2006) ‘framework for appraising the quality of qualitative research’ as reflective tool throughout the research process (see Appendix I). The framework was synthesized by mapping together pre-existing checklists and summaries. It consists of a number of questions that can be asked when carrying out research or reviewing research.

**Reflexivity**

Reflexivity is an important element of qualitative feminist research (Clews & Newman 2005; Doane 2003, McKay, Ryan & Sumison 2003). According to Finlay and Gough (2003, p. ix) ‘the etymological root of the word ‘reflexive’ means ‘to bend back upon oneself.’ This differs slightly from reflection which involves thinking about something after it has occurred. Instead, reflexivity ‘involves a more immediate, dynamic and continuing self awareness’. Josselson (2007) argues that the inherent ethics of narrative research is in the honesty of the researcher’s reflexivity. Because the researcher is the primary tool of inquiry, self knowledge and self reflection become essential. Reflexivity enables a critical attitude towards the influence of the researcher, context and subjectivity on all aspects of the research design, conduct, analysis and findings (Finlay 2003). Reflexivity should be evidenced during all stages of the research process and shared in the submission of findings (Malterud 2001). Wilkinson (1988) identified three distinct but interrelated forms of reflexivity. The first is ‘personal reflexivity’ whereby the researcher makes visible their individuality and its influence on the research process. The second, ‘functional reflexivity’ is about the role of the researcher, and the effect that role may have on the research process. The third ‘disciplinary reflexivity’ involves a critical approach to the place and function of the research within broader debates about theory and method.

Reflexivity was an integral aspect of my research process. In the introductory chapter of this thesis I share my own story and situate myself as the researcher in the research. In this chapter I explored and discussed my relationships with the participants, and the research topic throughout the collection and interpretation of data. The findings represent my interpretation of the narratives which was influenced by my own experiences and perspectives. They are presented to the reader not as ‘the’ truth about midwifery practice during birth, but as ‘a’ truth. A
truth that was co-constructed by myself, the participants, and our ‘storytelling relation’ (Frank 2000). It is acknowledged that a different researcher may have interpreted the data differently, reflecting their own background, experience and bias. However, a narrative approach underpinned by constructionism does not seek to uncover an answer that is generalisable or universal.

**Study limitations**

The midwives and mothers who participated in the study may not represent the ‘average’ midwife or the usual experience of birth. The midwives were interested enough to give up their time in order to contribute to my study, and in this way self selected. Therefore the voices of those who did not volunteer are unheard, and their experiences may be different. As discussed in the Introduction (p. 7), an uncomplicated vaginal birth without analgesia is not ‘the norm’ in Australia, therefore it could be argued that the mothers’ birth experiences are not representative of most. There was also a high proportion of homebirths and midwives who had attended homebirths. This may have influenced some participant’s perceptions and experiences of birth. The use of some snowballing recruitment may have also skewed the sample towards participants who represented a greater interest in normal birth than the general population. In addition, all participants were from one geographical space in a country with state-based maternity systems. However, a representative sample is only required if findings intend to generalisable, and this is not the aim of narrative research. The methodology enabled an in-depth inquiry with women who have given birth in different settings and midwives working in a range of settings within South East Queensland. Although findings are not generalisable, they may be transferable to midwives and mothers in other settings and circumstances and may guide future research.

**CONCLUSION**

This chapter asserted the importance of stories for women, midwives and mothers. It discussed the theoretical underpinnings of narrative inquiry as a research methodology, and a feminist approach to research. The methods used to explore midwifery practice during birth were described. The following chapters present the findings of this exploration.
Chapter 4

Introduction to the findings

The conceptual map shown in Figure 1 represents an overview of the research findings. The map illustrates midwifery practice during birth and its interaction with women’s experience of birth. The themes and subthemes are shown as intersecting and interdependent branches. Underpinning the themes is the explanatory framework ‘rites of passage’ which assists in enabling a deeper understanding, at an abstract level, of midwifery practice during birth. The following chapters explore these findings in greater depth, and they examine the synergy between women’s rite of passage, midwives’ rites of passage, and the parallel rites of protection enacted by midwives during birth. Chapter 5 focuses on women’s experience of birth, and Chapter 6 focuses on midwifery practice that aligns with women’s experience. Chapter 7 examines a parallel process of midwifery practice that does not necessarily align with women’s experience. This
chapter introduces the conceptual map used to illustrate the findings and provides an overview of the explanatory framework used to illuminate the findings. It also introduces the reader the participants who shared their birth stories.

**RITES OF PASSAGE: AN EXPLANATORY FRAMEWORK**

The explanatory framework 'rites of passage' helps to illuminate and explain the findings. The theory is applied to the findings in Chapters 5, 6 and 7, therefore an introductory overview of the theory is provided here.

The terms 'rite', 'rites' and 'ritual' are used throughout this thesis therefore it is important to define what is meant by these terms. The terms are often used interchangeably in literature, and definitions vary (Moore & Myerhoff 1977). However, in general the word 'ritual' is usually used to describe an act, whereas 'rite' tends to be used to describe a category of rituals, or series of rituals that make up a rite, such as the 'rites of passage' or 'rites of protection' (Heinze 2000). In this thesis I use the term ritual to describe a particular act or practice, whereas the term rite or rites refers to a collection of rituals. The term 'rite of passage' is also used to describe women's experience of the journey into motherhood; with the 'rites of passage' being the rituals performed during this passage.

In the early 1900s Arnold van Gennep (1909/1960), an anthropologist, analysed ritual behaviour in relation to the dynamics of individuals and society. In particular, he focussed on rituals attached to major transitional stages or 'life crisis' such as birth, puberty, marriage and death in small-scale societies. He found that for each life crisis, rituals are performed which aim to enable the person, or group of people to pass from one defined position into another defined position. Van Gennep referred to these rituals as 'rites of passage' and identified three phases associated with all rites of passage: separation, transition, and incorporation. These phases are also referred to as pre-liminal, liminal and post-liminal. Van Gennep noted that the importance and emphasis placed on each phase varied depending upon the life crisis event. During the phase of separation the person (or group) becomes disconnected from their current status. Separation rites often involve physically moving people away from their social group. In the transitional phase the person is in a liminal state, at variance with the one previously held. Whilst in this state they become 'sacred' to others who
remain in the profane state. This transitional period involves the performance of rituals aimed at cushioning the disturbance. Incorporation rites aim to re-integrate the person into the group, returning them to a new but customary status.

Van Gennep’s (1909/1960) theory has been widely applied and has helped to make sense of how transitions in life are embodied and socially incorporated (McCourt 2009). However, it is important to place the theory into the context in which it was developed. The tradition of positivism inspired van Gennep, and it can be argued that van Gennep’s writings are also somewhat ethno-centric. He considered well-defined rites of passage as a feature of ‘semi-civilised’ societies (p. 3). He acknowledged that ‘modern societies’ also had divisions of status and rites of passage, but that they were less distinct and subtler. However, it can be argued that such distinctions depend on who is viewing the rite of passage. For example, Bossard and Boll (1948) studied the rites of passage associated with the formal debut of young girls into Philadelphia society in the United States. Schwartz et al. (1999) explored the rites of passage experienced during high school graduation in the United States. From an outsiders perspective these Western rites of passage may seem far from subtle.

Victor Turner extended van Gennep’s framework based on his observations whilst living among the Ndembu people of Zambia from 1950 to 1954 (Abrahams 1995). Social theorists such as Durkheim and Weber; and British structural-functional ethnographers including Evans-Prichard influenced Turner’s work. However, Turner mostly built on van Gennep’s concept of ‘rites of passage’, and the structuralist work of anthropological theorists of the time. Turner’s focus was on the liminal, or transitional stage in rites of passage. His view was that these ‘betwixt and between’ times, at the threshold of transition held particular power. He argued that this period deserved special attention because of its potential for change, or for transformation and initiation to another level of consciousness (Mahdi 1987). He described how during rites of passage undoing, dissolution, and decomposition are accompanied by growth, transformation, and the reformulation of old elements into new patterns. In his book ‘the forest of symbols’ Turner (1967, p. 110) invites:

…investigators of ritual to focus their attention on the phenomena and processes of mid-transition. It is these, I hold, that paradoxically expose the basic building blocks of culture
just when we pass out of and before we re-enter the structural realm.

Turner (1967; 1995; 1987) referred to the person undergoing the rite of passage as a ‘neophyte’ or sometimes a ‘passenger’. Turner used the term ‘state’ to describe a physical, mental or emotional condition that a person or group is in. During the liminal period a neophyte ‘passes through a realm that has few or none of the attributes of past or coming state’ (Turner 1987, p. 5). According to Turner (1995, p. 95) at this time the neophyte is unstructured, at once both de-structured and pre-structured. Although they are physically visible, neophytes are structurally ‘invisible’ and are commonly secluded from the realm of culturally defined and ordered states. The indigenous term for the liminoid period is often the locative form of a noun meaning ‘seclusion site’. ‘The neophytes are said to ‘be in another place’ (Turner 1987, p. 98). In many cases liminality is considered to bring the neophyte into close connection with the unbounded, the infinite, the limitless, a deity, or with superhuman power. The liminal period is also a period of reflection whereby the neophyte is encouraged, or forced to think about their society, and the powers that generate and sustain them.

Important members of the social group such as Elders or Shaman often guide the neophyte through the liminal period. Turner refers to these guides as ‘instructors’. They use rituals to reflect the unstructured nature of the neophyte and to inform them of the new state they will join. Turner (1967, p. 96) described the symbolism surrounding the liminal persona as ‘complex and bizarre.’ Symbols of biological death may be used to represent the ‘structurally dead’ nature of the neophyte. Or norms will be inverted with neophytes being dressed in masks or clothes commonly worn by the opposite sex. Where instructors exist, they usually have complete authority over the neophyte, and the neophyte will submit to this authority. However, amongst neophytes there is often equality and communitas.

Turner, like van Gennep initially focussed on the rites of passage and liminality in small-scale communities. Turner (1967, p. 93) states that:

Rites de passage are found in all societies but tend to reach their maximal expression in small-scale, relatively stable and cyclical societies, where change is bound up with biological and meteorological rhythms and recurrences rather than technological innovations.
Again it can be argued that this conceptualisation of technology distancing humans from ritual reflects the culture of the observer. The use of technology can involve ritual elements, and technological societies continue to express ritualistic behaviour.

Van Gennep and Turner developed their theories within a patriarchal culture in which anthropology, along with other disciplines was predominately populated by men. Until recently, the rites of passage associated with childbirth have been generally overlooked by anthropology, reflecting a male-gendered bias (Davis-Floyd 2003; McCourt 2009). In 1981 Paige and Paige noted that most of the literature on rituals during pregnancy and birth had focussed on the male practice of couvade. Couvade involves a man acting as though he is physically affected by the pregnancy and birth, and undergoing particular rituals. The lack of public exploration of childbirth rituals may be the result of a number of factors. Childbirth has traditionally been situated in the domestic arena rather than the public one. This may have resulted in early anthropologists focussing on those aspects of culture that are more public, or more overtly political. It may also have been difficult for male researchers to gain access to the female controlled realm of birth within the societies they were exploring. It can be argued that even if they had gained access, their interpretation of events would have been through the lens of ‘the other’. In addition, Edith Turner (2000) suggests that in the Western world during the 1950s and 1960s the rite of passage into motherhood was disregarded as women were expected to carry on as normal and get back to work as quickly as possible. In more recent years anthropologists, in particular female anthropologists have explored birth, and rituals associated with birth in variety of cultures, both large-scale and small-scale, and the field ‘Anthropology of Birth’ has become established (Cosminskey 1976; Davis-Floyd 2003; Jordan 1993; Kitzinger, 1979, 2005, 2006; Selin 2009; Symonds 2004). Ritual during the transition to motherhood has also been recognised and explored outside the discipline of anthropology (Buckley 2003; Cheyney 2011; Hunt 1999; Niska, Snyder & Lia-Hoagberg 1998; Odent 2011; Paige and Paige 1981).

The theory of ‘rites of passage’ provides a useful framework for theorists examining women’s experience of pregnancy, birth, breastfeeding and early mothering. How the framework is applied varies, with differing perspectives regarding when the stages of separation, transition and incorporation occur. For example, Seel (1986), Machin and Scamell (1997), and McCallum and Reis
(2005) consider labour and birth as the transitional period with separation happening during labour. Davis-Floyd (2003) considers the events of pregnancy, birth, and early mothering as part of one single rite of passage, with separation beginning in pregnancy, and the height of liminality occurring in labour. Leap and Anderson (2008) also consider labour to be the liminal phase in the transition to motherhood. Pillsbury (1978) and Liamputtong and Selin (2009) focus on the postnatal period as the transitional stage with separation occurring at birth. They both studied cultures (Chinese and Nyob Nrua) in which new mothers are physically separated from society for a month following birth.

This thesis uses the framework of rites of passage to explain women’s experience of birth and the rituals midwives perform during birth. Like previous researchers I consider pregnancy, birth and early mothering to be one single rite of passage with separation occurring during pregnancy and early labour; and the liminal or transitional phase occurring in advanced labour (Davis-Floyd 2003; Leap & Anderson 2008; Machin & Scamell 1997; McCallum & Reis 2005; Seel 1986). The terms I use to describe the three phases of the childbirth rite of passage are: the separation phase, the liminal phase, and the incorporation phase. This reflects my focus on the liminal nature of the birth experience. In addition, I apply a feminist lens to the original patriarchal concept of rites of passage.

THE PARTICIPANTS

Without the participants and their stories there would be no findings. Each individual participant had her own unique story, and whilst the findings presented in this thesis are about the common themes, they were derived from these individual stories. Before moving on to further explore the findings, I would like to provide an introduction to the participants who contributed their stories. There were two participant groups comprising of 10 mothers and 10 midwives, although one of the midwives (Gina) also shared her own birth story, which was included in the data increasing the group of mothers to 11 in total. Pseudonyms were chosen by the participants and are used throughout in order to protect their identity.
Mothers

Whilst all 11 of the mothers had experienced an uncomplicated vaginal birth, they were a diverse group in many ways. Five of them were first time mothers having only given birth once. Of these first time mothers, Clare gave birth at home; Danielle and Anna gave birth in a private hospital; and Florence and Hillary gave birth in a public hospital. The other 6 mothers had all given birth to more than one baby, therefore had more than one birth experience. Whilst Emma and Gina gave birth to all of their babies at home, the other homebirth mothers, Belinda and Genevieve had both previously experienced hospital births. The remaining 2 multiparous mothers, Lola and Jane gave birth to all of their babies in hospital.

Each mother’s story was unique, and the boundaries of the ‘birth story’ varied considerably. For example, some mothers began their story with the beginning of contractions. For others the story began before conception, or with the births of previous children. In addition, the focus of each mother’s story reflected her larger individual narrative. For example, Emma shared her distressing experience of ultrasound scans and miscarriages. Danielle talked about the trauma of separation from her newborn following a postnatal transfer to a city hospital. Both mothers who had experienced previous caesarean sections (Genevieve and Jane) reflected deeply on their previous birth experience. For the mothers, this was their story, and as a feminist researcher it was important to listen and acknowledge their individual stories.

Midwives

The group of 10 midwives was also diverse in many ways. Their range of experience was from 18 months (Gina) to 25 years (Edith and Isla). Helen and Isla currently worked in a private hospital, although Isla had experience of providing homebirth midwifery care in the United Kingdom. Danika, Edith and Gina, currently worked in a public hospital. However, Gina also had experience of attending homebirths before and after qualification as a midwife. The two current homebirth midwives Faye and Julia also worked in hospital settings and shared stories about hospital births. In their narratives the midwives shared not only birth stories, but also their reflections on being a midwife, the settings in which they worked, the women they cared for, and the people they worked with.
THE THEMES AND SUBTHEMES

The themes and subthemes are presented in Figure 1. The figure shows women's experience of birth (childbirth as a rite of passage) intersecting with midwifery practice (rites of passage). This represents how midwives met mothers’ needs during birth. Mothers experienced birth as a journey through aloneness during which they separated from the external world; moved into their own world; and then afterwards integrated with the external world. This experience was aligned with the phases in rites of passage: separation, liminality and incorporation. Midwives' practice met the needs of mothers as they journeyed through aloneness by managing distractions, being with them, and assisting them to reintegrate with the external world.

Another aspect of midwifery practice (rites of protection) is also represented in Figure 1. The figure reflects the nature of these practices, in that they were not aligned with mothers’ experience of birth. These practices were carried out in parallel to the other midwifery practices (rites of passage), and aimed to protect both mothers and midwives. However, the messages conveyed by them were contradictory to the rites of passage. They disrupted aloneness, and undermined self-trust and inner wisdom.

CONCLUSION

This chapter introduced the findings and the conceptual map (Figure 1) that represents the themes and subthemes identified during the analysis of narratives. An overview of the explanatory framework 'rites of passage' and how I have interpreted it was provided. The two groups of participants, mothers and midwives were also introduced. The themes and subthemes represented by Figure 1 were introduced. The following chapters further explore the findings, beginning with women’s experience of birth in Chapter 5. This chapter distils women’s experience of birth, and provides a foundation for Chapters 6 and 7 which are about midwifery practice during birth.
I had the most awesome birth, I felt like holding my baby above my head with a triumphant roar like a warrior when she was born. Unfortunately the umbilical cord was too short!

(Emma, mother)

INTRODUCTION

This chapter presents the findings relating to mothers’ experiences of birth, and provides a foundation for the analysis of midwifery practice in the following chapters. The core themes arising from the data relating to women’s experience of birth were ‘a journey through aloneness’ and ‘self-trust and inner wisdom’ (see...
The themes are presented in linear order within the chapter, however they were intertwined within the narratives, and intersect with the themes presented in the following chapter. The quotes in this chapter are primarily from the mothers in the study because the focus is on their experience of birth. Once the themes have been presented, they will be related to the explanatory framework ‘rites of passage’ introduced in the previous chapter.

**A JOURNEY THROUGH ALONENESS**

**Separating from the external world**

As birth approached, mothers began to separate from the external world both physically and psychologically. For those birthing in hospital, physical separation occurred when they transferred to hospital; whereas women birthing at home isolated themselves from others within their home. Regardless of the setting, mothers sought to block out the external world and focus inwards. This inward focus assisted them to enter into the altered state of consciousness associated with being ‘in their own world’. Distraction from this inward focus could interfere with their ability to move into their own world, and could even slow or stop contractions. Therefore, mothers attempted to remove themselves from external and internal distractions.

**External distractions**

Mothers described how they avoided external distractions that could hinder separation from the external world. In particular they spoke about how they needed to be separate from other people and minimise sensory input. When Emma’s pregnancy continued beyond her due date she sent her toddler to her mother’s. She felt unable to focus inwards and go into labour whilst meeting the demands of her child. As she began to labour she called her midwife, but her labour stopped once her midwife arrived:

> Anyway, she got here and just… it was happening, but I felt like I was chasing the labour. And I could feel it starting to go and I just… oh no, no don’t go, but it did. And I probably just needed to go into my own space and be away from everybody to get into it. (Emma, mother)
Once labour became established Emma remained sensitive to sensory input:

And even having the water temperature change was like too unsettling, it was just the intensity would become overwhelming. And even hearing noises was too intense, [husband] actually flushed the toilet in the room and it was like I was in the water and it was spinning and I was... the whole thing, it just... too much sensory input going on. And I didn’t want to be touched in the labour, no, no input from anybody. (Emma, mother)

Hillary talked about how she wanted her grandmother to leave as her labour began:

...I think my mum came over and got my grandma, cos I didn’t want her... I wanted to be alone, I didn’t want to talk to anybody, I just wanted to be by myself. (Hillary, mother)

Later in hospital, Hillary described how she wanted silence during contractions:

...people around me kind of annoyed me a bit. [Partner] was texting people. I just kept going [clicking fingers] ‘shhh, shhh.’ Like I just wanted peace and silence with my contractions... (Hillary, mother)

Iola initially called her mother when she began to labour, but then realised she wanted to be alone, “…and then I just thought no, you know, I’ve got to centre myself and so I just said ‘leave me alone.’” Once she was in hospital she used the shower to block out sensory input:

...I was in the shower the whole time so the waters, the water could fill my ears so I couldn’t hear. Everything was muffled and all I could hear was like this... the music in the background... I wanted everyone to be quiet, like [partner] was running up and down the hallway with his thongs on, cluck, cluck, cluck, cluck... cluck, cluck, cluck, cluck, and I just remember from both births, cluck, cluck, cluck, cluck... ‘take them off!’ (Iola, mother)

A number of the mothers described retreating to the toilet or bathroom during labour in order to get away from distractions and focus inward.
Belinda had to address her need to be alone with her husband, and her midwife:

…we’d gone through a process of me being brave enough to say to him [husband] 'I need to be by myself as much as I know you want to be a part of this, you need to be over there… and I need to be here' [laughter]. (Belinda, mother)

“She [midwife] was giving me space which was what we realised I needed… like with both my labours I took myself away, I need not to have people looking at me.” (Belinda, mother)

Belinda had initially wanted to have a waterbirth but found the distractions involved were not helpful:

We’d chucked the waterbirth out as much as I loved the concept, it was too much of a pain in the butt to keep the water the right temperature. And again then there was too many people around and too much noise. And literally I just wanted ear plugs in my ears and quiet. (Belinda, mother)

Clare, Emma, Genevieve and Iola all described having their eyes closed during labour, which blocked out visual sensory input.

For Jane the distractions associated with transferring to the unfamiliar environment of the hospital stopped her labour, “then it stopped just as soon as I got to hospital”. Once she left hospital to return home her contractions returned: “yeah as soon as we left the hospital I went straight back into contractions, and then they kept starting the whole way home…” As labour progressed and mothers were deeply ‘in their own world’, external sensory input seemed to have less of an influence over their labour progress. Mothers who arrived at hospital very close to birthing (Iola and Hillary) did not appear to be affected by the environment. When Jane returned to hospital she was close to birthing and the hospital environment did not influence her contractions as it had earlier in her labour.

Internal distractions

The ability to separate from the external world could also be influenced by internal distractions such as emotions and thoughts. Mothers were aware that
they needed to resolve and separate from emotional issues before labour began. This seemed particularly important for the two mothers planning a vaginal birth after caesarean. Both of them sought outside help during their pregnancies in order to release disruptive emotions and fears. Genevieve had a session with a midwife she knew, “and we just did some breathing stuff and worked through some of my fears and stuff from last time, and that had been really helpful.” Jane described her process of releasing past emotions using essential oils:

I found out they say that older women find it hard to give birth naturally than younger women, and I think I discovered the reason when I did all my things. It’s not because of the age which they say, and all the science, it’s because when you give birth you have to let go and release. And when you’re older you’ve got more things that are inside of you. And when I was using the oils, all these things started coming out that happened to me. Yeah which I thought was really interesting yeah to release. Um you know things from my past that had happened, emotional, deep emotional things, they all came out. (Jane, mother)

Hillary sought help from a counsellor to release her fear about hospital, and to address concerns that her baby would inherit her medical condition. Throughout her childhood she had had regular surgery to manage growths on her vocal chords:

So I wanted to make sure I didn’t have a fear and that my labour would slow down when I got to hospital. Um and then I was scared that the baby might have the same condition as myself. So I went to her and she goes ‘nah, you don’t have a problem, you’ll be fine. (Hillary, mother)

The need to clear internal distractions arose during early labour for some mothers. Belinda felt that her emotions surrounding a previous gynaecological procedure prevented her labour from progressing. She had had surgery following an abnormal smear result, “…and so I think they’d taken out something that was meant to be there or something.” Her labour stopped as she remembered this experience:
Like literally the power of the mind... you know I had some emotional stuff I needed to work through... that came up really clearly. Issues around actually owning my uterus cos when I’d had the operation I was quite young and I remember a doctor saying to me, ‘it’s a shrivelled up old prune and you probably don’t have to worry about contraception anymore anyway’. Cos I really didn’t think I could have children. So, that emotion around my uterus was really blocking everything. It was just coming up a belief that it didn’t work. (Belinda, mother)

Belinda “worked” through her emotions for 2 weeks before labour re-started. Emma also described how she cleared internal distractions during early labour. She had “family stuff going on” and thought she had already dealt with it, but as she began to labour “all this stuff came up.” She’d also “had this other person warn me that I may need to have a caesarean this time, so that was in my mind.” Emma described how she cleared her internal distractions:

I actually was in the contraction squatting and I had a real sort of connection with this person, in my own mind anyway, and I said to this person in my mind ‘I really need you to believe in me, that I can do this’. And as soon as I did that one, my labour just clicked into gear, it really was quite odd. (Emma, mother)

She then went on to express her emotions to her husband and midwife, “and I had a few other things, and I had to come out and say stuff to [husband] and the midwife.” This allowed her labour to move forward, “the labour really kicked into gear and I got into the water and was labouring.”

In their own world

As labour progressed mothers experienced an altered state of consciousness. In this altered state, separation from the external world was maintained and they focussed within themselves. Mothers’ used spatial terms to describe their state such as ‘zone’, ‘planet’, and ‘land’. For example, Jane described her altered state of consciousness as, “just like being on another planet.” Whereas, Anna talked about being in the zone: “I really think that I was totally in the zone at that time.” The altered state of consciousness was very different from the mother’s usual state of consciousness. Jane referred to her state in labour as, “completely
insane” and Gina described it as, “kind of surreal.” Others likened the experience to being like an animal:

And I felt like an animal, I felt just ah docile, I was trying to crawl out of the pool with all my energy but I didn't want to get out of the pool cos it was so nice and warm. And you just, you've got no idea at the time, you're just doing what... you're totally an animal... I’m kneeling on all fours facing away from [partner], holding onto the side of the pool, crawling like an animal to get out of the pool [laughter]. (Clare, mother)

Genevieve also alluded to the animalistic nature of the birth experience when she described the noises she made, “there was one point on the toilet where I was... I had to laugh to myself, I was like 'aarrggghh, rraarragh', and I'm like 'I'm like a pirate lion' [laughter]." Some mothers described their state of consciousness as meditative. For example, Hillary explained:

…I felt like I was in an animalistic kind of meditation, weird sort of feeling, where I didn't really know what was going on around me, and I didn’t want to be disturbed… like in another state, like in a state of mind I've never experienced, like a yeah, like a deep strange meditation sort of thing. (Hillary, mother)

Gina also described her experience as being like meditating, “being in a different state of mind, yeah altered state of consciousness I suppose, like meditating, yeah”, and it was “almost like being drunk”.

Whilst in an altered state of consciousness mothers behaved in ways that were not consistent with their everyday state. For example, Hillary described lying down on the hospital corridor floor during contractions like a ’drunk dero’; and when Iola arrived at hospital she was close to giving birth:

And so once we got to the hospital we parked out the front... you know I'd go five metres and then I was on my hands and knees on the ground again. And then I broke my waters... like put my hand in and broke the waters... it was, cos I could feel the balloon.... And so I broke that when I was out the front of emergency on the footpath, and then um whilst throwing some bits of poo into the garden [laughter]. (Iola)
Whilst in an altered state of consciousness mothers were able to let go of social norms and expectations regarding behaviour.

Mothers also mentioned experiencing an altered sense of time:

... you don't really have much concept of time anyway. (Anna, mother)

And you just, you've got no idea of the time... (Clare, mother)

...time didn't really exist any more, and the rest of the world kind of disappeared. (Genevieve, mother)

Some considered that the time spent in labour was related to how far into ‘their own world’ they went. The longer the labour, the deeper they got. Gina was disappointed that she didn’t get as deeply into “labour land” during her shorter second labour:

I've never been able to get back... to that place. And I was really looking forward to doing it again with [second child], but she just came too quick, and I never quite got there... and I don’t know whether maybe labour land is the key ingredient to a beautiful birth, I don’t know [laughter]. (Gina, mother and midwife)

Gina described how she “craved” for the altered state of consciousness she had achieved during her first birth and wished her second birth had been longer. Belinda, and Iola also felt that a shorter labour hindered their ability to get deeply into an altered state of consciousness. In contrast, Genevieve whose labour was long, described how she almost got lost in her own world.

... I was definitely in labour world which is really nice to be. Yeah it was really um sleepy, and dreamy and just felt kind of heavy and relaxed and slow. I don't know, it's hard to explain, um yeah... I don’t know. I didn’t really... time didn’t really exist any more, and the rest of the world kind of disappeared... I think at some stage there I did start to spin out a little bit. I remember [midwife 2] was yeah, checking my pulse and stuff and I can’t remember exactly what was going on but they were telling me to come back [snapping fingers] a little bit. Like
I do remember just kinda standing up and opening my eyes 'like take a big breath' and I'm like [big breath] OK yep, I'm here, this is what's going on, right OK. Cos I just could've got lost in that world I think. It was um pretty nice there [laughter]. (Genevieve, mother)

Reintegration with the external world

After birth mothers reintegrated with the external world, slowly emerging from their own world. Clare described how she took a little while to emerge from her own world:

...from the photos afterwards I saw that I was basically a stunned mullet for about 10 photos. I have got the look on my face like 'oh' you know like just a bit of shock still. Like I don't really know what's going on. And there's like about 10 photos like that and then all of a sudden there's one I'm smiling [laughter] finally I'm like 'yeah!'. (Claire, mother)

After the birth mothers experienced a sense of that something ‘other worldly’ had occurred amid the normality of the external world. Anna remarked on how strange it felt to be eating lunch only a couple of hours after giving birth:

It was just so funny cos you know there was lunch for us, and you know he’s sitting in his crib... and my husband and I are sitting there eating lunch going [laughter]... this is, you know, not what we sort of expected at all. (Anna, mother)

Genevieve came out of her bedroom in the middle of the night to find her midwives had tidied her sitting room:

And I came out in the middle of the night and I looked around and I was like ‘who would’ve even known what happened here today, [laughter] it’s all lovely’. (Genevieve, mother)

Mothers physically reintegrated with people in the external world along with their new baby. Belinda described her reunification with her immediate family after her homebirth.
...came up stairs to the family who hadn’t even known we were having the baby cos I hadn’t mentioned it, so that I could have my privacy [laughter].... I didn’t tell them my waters had broken, I just snuck off [laughter] to do my thing in the middle of the night and they woke up at... it was dawn, the, the sun was rising as we put her on the bed between us, she, she made a noise and... the doors started opening in the house... The girls went ‘what’s that, what’s that... it’s a baby crying, it’s here!’ and they all came barrelling into the bedroom, it was so wonderful. So then all the other brothers and sisters came from all around, and by 10 o’clock they were all on the bed, in the bedroom, the whole family chatting away. (Belinda, mother)

One mother in the study, Danielle was physically separated from her newborn shortly after birth. Her daughter was transferred to a city hospital with breathing difficulties and stayed there for four days before being transferred back to the regional hospital.

I went to the [city hospital] where they took her... They wouldn’t let me, they said ‘we can admit you, but you can’t go in the nursery during the night and stuff’, they close it like you know unless your kid needs feeding or something, in which case they’re all being fed by tubes. (Danielle, mother)

This experience was traumatic for Danielle, and she eventually sought the help of a counsellor, “I had to end up going to see a counsellor at [hospital] and stuff cos I was just a mess, not really functioning...” Danielle’s reintegration with the external world was disrupted by her baby’s admission to hospital. Danielle was the only participant who talked about struggling to adjust to mothering, and she was also the only participant who experienced physical separation from her newborn.

**SELF-TRUST AND INNER WISDOM**

As discussed previously, mother’s retreated into their own world during labour to avoid distractions from the external world. Whilst they were in their own world they relied on their inner wisdom to reassure and guide them. In preparation for labour mothers cultivated self-trust.
Cultivating self-trust

During pregnancy, mothers actively built trust in their body and their ability to birth. Some found that formal childbirth classes helped them to gain confidence in themselves. Three of the first time mothers in the study, Anna, Danielle and Florence, attended hospital based antenatal education. Clare, who was planning a homebirth learned about the physiology of birth from the Pink Kit® (an educational resource), “and unbelievably that helped me, you know...” She knew that her own movements, and the physiology of her pelvis would assist her to birth:

...you don’t need to go for an emergency c-section if you know where your baby is inside you, you can move your body. You know there’s so many people that get told that their hips are too small. It's like dude you’ve got ligaments, they’re gonna stretch, your hips are gonna go into whatever shape you want. (Clare, mother)

Clare’s midwives also talked to her about birth, “they had a little bone structure and a baby doll that they used to show you how... this is how your birth can happen.” Lola, Hillary, Belinda and Genevieve used HypnoBirthing® (Mongan 2005) techniques to prepare for labour, although none of them attended sessions with a certified HypnoBirthing® practitioner. The HypnoBirthing® approach reinforces the body’s innate ability to birth, and provides relaxation and breathing preparation. Lola described how reading about HypnoBirthing® helped her to prepare for labour:

A lot of the time complications I think are just from people being so scared that they just tighten up their whole body and don’t actually allow their body to have a baby... [Friend] gave it to me to read and um, and so I just, I guess I just thought you really need to trust your body, and if you can breathe through it then... and not get too stressed and if you control you’re breathing then everything will work out. (Lola, mother)

Mothers reinforced to themselves the notion that self-trust could contribute to a good birth experience and reduce the chance of complications.
Previous positive birth experiences also contributed to mothers’ self-trust. Conversely, previous negative birth experiences could interfere with their ability to trust their body. The two mothers who had previously had caesareans worked hard to build self-trust. Jane researched thoroughly and ensured she created the best conditions for a vaginal birth by hiring a Doula. Genevieve found that even though her previous birth had been disappointing, the experience had helped her to gain confidence in her ability to birth again. In particular her mothering and breastfeeding experience helped her to build trust in her body for her next birth:

Even though [first child] was born by caesarean I just think that um yeah, my trust in myself, and that knowledge about myself grew a lot. I was like ‘man if I can have an epidural, I can do anything [laughter]!’ And I just, I felt like I just naturally knew how to look after her too. Like as a new mum I just felt really fine, and I know what my baby needs and I can do that. And you know never questioned being able to breastfeed or anything. So the second time round I’m like well if I didn’t question my body’s ability to feed my baby, why do I question my body’s ability to get my baby out? (Genevieve, mother)

Knowledge about female relatives’ births also helped mothers to build self-trust. Emma, Hillary and Jane talked about how knowing that other women in their family had birthed without problems reinforced their own confidence. In contrast, Genevieve reflected on how knowing about her mother’s pre-eclampsia negatively influenced her self-trust during her first pregnancy. This mistrust of her body was compounded when she developed raised blood pressure, and her baby did not engage in her pelvis. Mothers also gained confidence in their ability to birth by listening to other women’s experiences. Anna and Danielle attended a mothers group and found that listening to other women’s experiences of birth helped them to trust the birth process.

Mothers also talked about how they relied on intuitive knowing during pregnancy to help them foresee and prepare for birth. During pregnancy mothers trusted and acted on their inner wisdom. For example, during a hospital appointment Jane was diagnosed as having raised blood pressure, and the obstetrician wanted to admit her for medication and observation overnight. Jane went home to collect clothing but did not return, “…when I came home I had this really bad intuitive feeling about everything… I said ‘I’m not going back in there’.” She asked her
husband to ring the hospital and say they were unable to return due to flooding. Jane did not return to hospital until she was in labour days later.

Emma, Genevieve and Hillary described having intuitive knowledge about the circumstances of their future birth experience. For example, Emma knew that she would have a fast labour with her third baby:

…this time I really, really felt that I was going to have a very fast labour. And I was really frightened of going into labour again because I felt it would be less than 2 hours. I always had this picture of about an hour in my head, I just knew this was going to happen. (Emma, mother)

Hillary imagined when her labour would start, “I imagined… mid-week um early afternoon, imagined all that, and that’s what happened.” Genevieve had a feeling she would go into labour on her birthday, “I had a feeling that I always would go into labour that day, which I did.” It was unclear whether the inner knowing described by mothers was foretelling the future, influencing the future, or coincidence. For example, Iola described how she consciously influenced her birth experience through imagination. During her regular swim in a 9.0 metre pool she repeated the words “90 minute labour, 90 minute labour.” Her labour was 90 minutes, “…what I had imagined and thought of over the months, I did create…” Genevieve experienced dreams during both of her pregnancies about her subsequent births. During her first pregnancy she had a recurrent dream about a caesarean birth:

…she [baby] was kind of clawing through the skin of my stomach and things. And there was like all this kind of flesh… it sounds really gross but… and um yeah like she just… she never came out my vagina. (Genevieve, mother)

As birth approached, her baby did not engage into her pelvis, “she just wouldn’t get in there properly which stressed me out.” After a long labour Genevieve’s first baby was born by caesarean. In her second pregnancy, Genevieve had a very different dream:

And a the start of my pregnancy just not long after I found out, I had a dream that um I was giving birth and I was in a corner of this room, and I was all by myself and I was kneeling down. And
I was like ‘oh gosh this baby’s coming, I don’t know if I can do it’ and I was like ‘yes, you can do it’, and I did it, and I birthed this baby beautifully on my own and I just really took that on board. (Genevieve, mother)

The message Genevieve took from this dream was, “I need my privacy during this labour, and I need to feel safe, and I need to do this on my own.” She felt that during her first birth she had focussed on what her midwife would do, whereas for her second birth, she focussed on herself, “I really learnt that it’s me that’s going to birth my baby.” In addition to dreaming, Genevieve used visualisation to prepare for her second birth:

I’d done a lot of visualisation during my pregnancy too, and just nothing specific but just what came to me was that I was in the pool and I just reached down and I picked my baby up. And that was a really important thing, and that I held onto that too. (Genevieve, mother)

Her second birth was as she had visualised, “…and then he was born and I just reached down in the water and picked him up, just like I had seen.” Belinda used visualisations to prepare for birth, “I’d spent 2 weeks visualising my uterus opening like a rose, and I’d been given a picture... a beautiful picture of a crowning head with sort of this rose, like rose petals.” Emma also described her use of a visualisation based on a birth story she had read:

I’d been reading Ina May’s book that I was visualising that my vagina would be huge because this woman had birthed like an 11 pound baby or something and no tears, and everything had worked. (Emma, mother)

Inner wisdom at work

The self-trust mothers built during their pregnancy prepared them for the birth experience. Once mothers trusted their inner wisdom, they could birth intuitively, and reach inwards for knowledge about wellness. For example, Belinda described trusting that she would know if anything were wrong:

…but I was really tuned in at that point, I would have known if there was anything wrong. So, I just trusted… (Belinda, mother)
Emma also remarked that, “I think I would know if there was anything wrong.” Mothers described connecting to, and being very aware of their body working, and their baby moving through their body. They ‘let go’ of the external world in order to focus inward. For example, Clare knew where her baby was in her body and felt her pelvis making space for him.

I remember feeling my sacrum just pushing out, could just feel it popping out. So that you could tell where the baby’s head was at that stage, you knew oh it’s moved down a little bit more. (Clare, mother)

Emma talked about being very aware of what was going on inside her body:

…the uterus was squeezing down I was starting to feel my cervix… felt almost like it was really closed whereas with the other labours I’d actually felt my cervix, with [second child]’s in particular when he was screwing his head around on it I could feel my cervix opening a couple of centimetres, at the time it was like a spring just going boing, boing and that made me laugh… I was so inside myself, and so right there at my cervix that I could almost see it all happening. (Emma, mother)

Genevieve and Hillary described the experience of their baby moving through their body as ‘amazing’ and ‘empowering’:

I could just about every contraction, I could feel him coming down through my pelvis and that was just amazing. I felt really good. (Genevieve, mother)

And um yeah I just kept on talking to the baby and… Empowering, yeah it felt good. And um it felt… I remember feeling my hips when he was actually coming down. And I thought ‘Oh God, this is huge.’ So that was a weird feeling. (Hillary, mother)

A connection with the baby during labour was common amongst the mothers. Like Hillary, Belinda described having a dialogue with her baby during labour:

…and talking to her, and walking with her through the birth canal. And, and I’d done that naturally with my other 2 as well. I
knew exactly where they were, although I wasn't talking to them back then like I could with this one. So I knew where she was and how it was going, it was very intense… (Belinda, mother)

Some of the mothers talked about how they used their body to assist the birth process. Emma lay on her left side to help her baby rotate: “…so I lay on my left and I knew he’d turn automatically, which he did.” Hillary also intuitively knew how to help her baby turn:

So every time I had a contraction for some reason I’d have to lie on my left hand side. And I think in hindsight it was because he was on the right hand side. His back was down here and I wanted to turn him. (Hillary, mother)

Half of the mothers in the study described a point in their labour where they experienced self-doubt and felt overwhelmed. Danielle described how she remembered, “…being in the shower feeling like I wanted to kill myself, I was crying…” Anna suddenly began to think “oh no, something’s wrong.” However, this self-doubt was short lived and usually relieved by their midwife (see Chapter 6).

It was not until the expulsive phase of labour that mothers talked about their body taking over control. Prior to this phase mothers were able to control and override their body, and in some cases hold back, or halt their labour. But, as the birth became imminent they described experiencing an overwhelming and uncontrollable urge to push. Anna felt she had no control over her body at this point:

…you’d actually bend over without any sort of control, control over it at all. I hadn’t expected that the urge to push could be so, so strong. (Anna, mother)

Emma talked about how the push came into her body:

…all of a sudden the push just came into my body and I didn’t even consciously push, it just happened. And I started pushing for about… I actually never pushed once, my body just did it… (Emma, mother)
During preparation for birth Belinda learned about, “the HypnoBirthing® concept of allowing it to happen” and “had no intent of pushing”. However, despite her intent she, “…definitely felt a massive urge to push.” Mothers did not seem to perceive the lack of control during this time as a negative experience, but as further evidence of their inner wisdom at work.

Empowerment

Mothers talked about their birth as an empowering and transformative experience. For example, Belinda described her birth as: “…very empowering you know, very empowering and rewarding, and beautiful…” Emma described feeling “like a warrior” after birth. Mothers absorbed new knowledge and understanding about themselves and incorporated this into their sense of self. Isla, a midwife, shared an experience of caring for a woman who was transformed by her birth experience. The woman had previously been in an abusive relationship and had very little self-confidence. She had a new partner and was pregnant with her fourth baby. Unlike her previous births, she decided to birth at home. Throughout the pregnancy and labour she had little confidence in her ability to achieve a homebirth. Eventually this woman gave birth without medication, at home:

Do you know that woman was going around on cloud nine for weeks afterwards. Every time [laughter] she saw me she said ‘I did it, didn’t I, I did it?’ And she did [laughter]. And I mean she was so… I think she’d been so cow-towed by the previous man she’d got no confidence in herself. And seeing her go through that labour, you know fortunately I’d seen her all the way through the pregnancy, right from booking, right through, and the postnatal afterwards. It was amazing. That timid little woman had blossomed into this amazing force to be reckoned with [laughter]… talk about empowerment at its best, I mean she was walking around, nothing could touch her, she was Amazonian you know. She’d given birth to this baby and she’d done it. She was telling everybody ‘I didn’t have any drugs.’ She says ‘I didn’t have anything. I thought I was going to, but I didn’t.’ And she was just absolutely high as a kite. (Isla, midwife)
Experiencing inner wisdom at work appeared to generate further self-trust and a sense of achievement for mothers. In contrast, three mothers in my study had previously experienced a disappointing or traumatic birth. They described a sense of disempowerment associated with these births. For example, Emma’s first three babies had required assistance from her midwife to birth their shoulders. The second time this happened she found the experience “quite traumatic” as there was “a pattern forming, and it was all starting to build up.” The third time her baby got stuck she was “just devastated” and said to her midwife “‘why can’t they just come out, what’s wrong with me’.” The two mothers who had previously had caesarean sections described their feelings afterwards. Jane said:

…after that caesarean I felt like I’d failed [first child] and I had really bad feelings about it. (Jane, mother)

Cos you’re whole body’s just made to do that. There’s something that feels ripped off. (Jane, mother)

…I felt totally victimised, like my whole soul or something, after that experience I had… the uterus is such a powerful muscle, and for it to be cut is… it’s almost like a feminist issue in a way to me, um it’s to tamper with that part of you. (Jane, mother)

Genevieve said:

…women in the hospital who get told ‘you’ve got your healthy baby that’s all that matters’ Like that’s such bull shit. It’s not all that matters, like you know, yes everyone wants a healthy baby, and that is like the most important thing. But the journey is so important too, and I just… um I think that I could of gotten really depressed if I had of been one of those people in the hospital who just that’s it, end of story, see you later, get on with your life kind of thing. And um I just didn’t have that acknowledged you know and I really needed to grieve, you know over the birth that I didn’t have and things. (Genevieve, mother)

The birth experience had implications for mothers’ self esteem, confidence and self-trust. This influenced how they approached a subsequent birth, and as previously discussed, mothers often felt they needed to clear negative emotions as they approached subsequent births. However, the three mothers who had
previously had disappointing births expressed a strong sense of empowerment and healing through their subsequent birth experience. For example, Emma described her fourth birth, where her baby was born easily and unassisted by her midwife:

So I just picked her up and I, I was cheering, I was like ‘yes, I’ve done it!’ It was just brilliant and we were both sort of like crying and laughing. (Emma, mother)

Having a vaginal birth was extremely important for Genevieve as a means of healing from her previous experience. When she became pregnant again she admitted that:

...part of me really wanted to have another baby just to do it right. I know that sounds really stupid, but um, you know, and then I felt really guilty about ah this poor little person, I've just brought you into the world to like fix my shit [laughter].

(Genevieve, mother)

After her second birth she felt that she had “achieved something really wonderful and um I did it, and that was really cool.” Jane described her vaginal birth as “the most incredible experience of my whole life,” which enabled her to regain confidence in her body and her life:

I also got my confidence back in life cos I’d lost my confidence after that experience. (Jane, mother)

And also um it... when you do that as a woman, you know you can do anything. (Jane, mother)

I realised how everything else in life is easy, if you can do that (enduring 70 hours of no sleep, wild contractions etc) you can do anything. I am sad that so many woman don’t get to understand this. (Jane, mother - via email)
CHILDBIRTH AS A RITE OF PASSAGE

The mothers’ experience of birth can be understood as a rite of passage. Rites of passage comprise of three phases: a separation phase, a liminal phase and an incorporation phase. The subthemes identified from the data relate to these phases of the childbirth rite of passage.

Separation phase
(subthemes: separating from distractions / cultivating self-trust)

…the first phase of separation comprises symbolic behaviour signifying the detachment of the individual or group either from an earlier fixed point in the social structure or a set of cultural conditions (a ‘state’). (Turner 1987, p. 5)

The first phase in a rite of passage involves separation from one’s previous state and place within the social and cultural structure. As the mothers in my study approached labour they described separating themselves from the distractions of the external world. They sought out ways to block out sensory input and avoided interactions with people. In doing so they physically separated themselves from the social structure of the external world. Physical separation from society during pregnancy and birth is common throughout history, and across cultures (Jordan 1993; Liamputtong & Selin 2009). Van Gennep (1909/1960) wrote about the separation phase in childbirth rites of passage; and described how women were commonly placed in a state of isolation during pregnancy and birth in either special huts or a special part of the home. In some cultures women are entirely isolated from people during birth. For example, van Gennep (1909/1960) described how the Hopi of Oraibi (in Arizona) birthed alone. The moment of childbirth was considered sacred, and no one except the birthing woman could be present as the baby was born. Today, Hmong women give birth alone, particularly for their second and subsequent births (Symonds 2004).

In modern large-scale communities, physical separation usually occurs in labour rather than during pregnancy. Women labour and birth in seclusion from society, either within hospitals, birth centres, or their home. This cultural norm is reflected in the continued use of the term ‘estimated date of confinement’ to describe the date that labour is expected to happen (Ananth 2007; Baskett & Nagele 2000). The mothers in my study all sought physical seclusion during labour, and they
also sought to clear internal distractions. They address emotional concerns and fears, separating themselves from these internal distractions. They also built trust in their ability to birth during pregnancy which assisted them to prepare for labour where they needed to draw on internal resources rather than rely on the external world from which they had separated.

**Liminal phase**
*subthemes: in their own world / inner wisdom at work*

The attributes of liminality or a liminal *persona* ("threshold people") are necessarily ambiguous, since this condition and these persons elude or slip through the network of classifications that normally locate states and positions in cultural space. Liminal entities are neither here nor there; they are betwixt and between the positions assigned and arrayed by law, custom, convention, and ceremonial. (Turner 1969, p. 95)

After the separation phase, a person undergoing a rite of passage enters the liminal phase (or transitional phase) where they are often said to ‘be in another place’ (Turner (1967, p. 98). For the mothers in my study the liminal phase occurred when they were in established labour. Davis-Floyd (2003) suggests that the physiological processes involved in birth create a naturally liminal state – the rhythmic contractions of the uterus; the psychological state created by birthing hormones; the intense physical and emotional experience. In my study there appeared to be an association between the time spent in labour and the depth of the liminal state mothers were able to reach. The longer the physiological process, the deeper the liminal state.

The intense experience of labour required mothers to ‘undo’ their usual state of consciousness, behaviours, and their connections to the external world. They described being ‘in their own world’, in an altered state of consciousness. They used spatial terms to describe the experience of being in another place, for example ‘land’, ‘planet’ and ‘zone’. This space appeared to be located within the labouring mother, and some likened it to meditative experience. As mothers progressively moved more deeply into this internal world they shut out the external world further, maintaining and increasing separation. Symonds (1991, p. 265) describes birth as a liminal period in which the mother and her baby are in an ‘in-between’ world, and Davis-Floyd (2003) considers labour to be the most
intensely liminal phase in the childbirth rite of passage. During labour a woman is quite literally between the states of pregnancy and motherhood. It can be argued that this is reflected in the use of the term 'in labour' which suggests being somewhere rather than a status. In contrast, women are 'pregnant', not 'in pregnancy', and they are 'a mother', not 'in mother'. In addition, the unborn baby can be considered a 'liminal entity' (Hogan 2008, p. 145). During labour the unborn baby is between states, moving from a fetus, hidden within a body, to a baby recognised as a person by the society he or she joins. This 'in-between' status is reflected in the 'in-between' state of consciousness that mother’s described experiencing.

During the liminal phase, Turner (1987, p. 5) suggests that a neophyte ‘passes through a realm that has few or none of the attributes of past or coming state’. At this time the neophyte is unstructured, at once both de-structured and pre-structured. The mothers in my study acted in ways that reflected their unstructured nature. The extreme physical process of birth involved their bodies functioning in a way that was unlike the everyday functioning of their body. Their behaviour was inconsistent with cultural norms. For example, the ‘animalistic’ noises they made during labour, and unusual behaviours such as lying down in hospital corridors. Turner (1987) also described liminality, as an undoing, dissolution and decomposition. Half of the mothers in my study reached a point in labour where they described experiencing feeling overwhelmed with self-doubt at a point in their labour. It can be argued that this experience is aligned with Turner’s notion of liminality as an ‘undoing’.

**Incorporation phase**
(subthemes: reintegration with the external world / empowerment)

Undoing, dissolution, decomposition are accompanied by the processes of growth, transformation, and the reformulation of old elements in new patterns. (Turner 1987, p. 9)

In all rites of passage, the third phase involves re-assimilation or incorporation of the person back into society in their new state (van Gennep 1909/1960). The state of motherhood and personhood (for the baby) happens immediately following birth. However, the reintegration of mother and baby back into society occurs progressively. Van Gennep (1909/1960) noted that women were physically isolated or subjected to unusual restrictions following birth before
reintegration. In some cultures women have extended periods of separation from society following birth before being reintegrated. For example, Chinese women, and Hmong women spend 30 days after birth separated from society (Liamputtong & Selin 2009; Pillsbury 1978). The mothers in my study described how they reintegrated first with their baby and partner, then close family, before later reintegrating with extended family and wider society. However the transformative nature of birth is not limited to becoming a mother. The mothers in my study talked about the empowering nature of the birth experience. Turner (1987) also identified the power of the liminal phase as a process for inner growth and transformation. Mothers incorporated the birth experience into their sense of self, resulting in empowerment, and for some, healing.

CONCLUSION

This chapter presented findings about women’s experiences of birth. The core themes arising from the data were ‘a journey through aloneness’ and ‘self-trust and inner wisdom’. The experience of birth was further illuminated using the explanatory framework of rites of passage and conceptualising childbirth as a rite of passage. This chapter provides a foundation for the following two chapters which present findings regarding midwifery practice during birth. The following chapter discusses midwifery practice that is aligned with women’s experience of the childbirth rite of passage. Chapter 7 explores midwifery practice that is not necessarily aligned with women’s experience.
…generally I’m just sort of trying to stay as much in the background as much as possible, so that… I mean it’s her birth, it’s not mine, it’s hers. So the more she can do herself, then you know that’s, that’s the better thing. And it’s trusting themselves as well. (Isla, midwife)

INTRODUCTION

This chapter presents findings about midwifery practice during birth, in particular the practices that are aligned with women’s experience of birth. It examines what midwives do and why; and how women experience midwifery practice. Whilst most of the quotes are from midwives, quotes from mothers about their
experience of midwifery practice are also included. Including mothers’ perspectives allows an exploration of the synergies between midwifery practice and women's experience. Two core themes emerged from the data which are directly related to the core themes identified in the previous chapter (see Figure 3). These themes and subthemes are presented and then explored further using the explanatory framework to conceptualise midwifery practice as ‘rites of passage’.

**TENDING THE BOUNDARIES OF ALONENESS**

The previous chapter discussed how mothers focussed inwards during labour and attempted to block out external and internal distractions. Midwives assisted by managing distractions that emerged from the external world, and by helping mothers to clear their internal distractions.

**Managing distractions**

*External distractions*

External distractions were common during labour and originated from the environment the mother was labouring in. Midwives aimed to create a private environment and minimise interruptions and interactions. They limited their own verbal interactions with mothers, for example, Faye described how she approached a woman in labour, “I go in and I meet them, I get to know them a little bit without much words at all…” Becky also explained how she minimised talking:

> So I try not to do too much talking at all. If I need to, I try and talk to them between contractions, and early in the labour, so that they can then keep the focus on what their bodies are doing or what they need to do. (Becky, midwife)

Midwives also attempted to reduce the amount of talking others did whilst around the labouring mother:

> I really encourage the people that are around her to try and keep talk to a minimum… just encourage them not to ask her questions. If she looks like she might like some ice chips or a
drink, just put it up to her mouth and she'll take it if she wants it, if not she'll ignore you, and you know that's a ‘no’. (Gina, midwife and mother)

Danika described how she encouraged an excited partner to reduce his distracting interactions:

And then her partner came in and he was beside himself because he had this massive story of um, you know how the car had broken down, and his mum, and this and that... Yeah, and then when he came in, he was blaaahblaaah and it was sort of taking... it wasn't really taking her away from that place cos she was actually quite there. But, I went to get some hotpacks and I grabbed him to come with me, and I sort of explained where we were at, and just gave him a little bit of a run down of my... Um so when we came back into the room, he was wanting to you know... finger to mouth kind of um ‘shhhhh’ [quietly]. And he got it, so we didn't actually have to talk too much after that [laughter]. (Danika, midwife)

Midwives acknowledged mothers’ needs regarding being alone and private during labour, "she’s in the dark, she’s in her zone, she’s got the lights off, all soft, she’s hiding in the shower" (Faye). They altered the physical environment to mirror this need:

... just try and keep the room nice and calm, dark, try and you know make the ins and outs of the room to a minimum. Don't have too many people knocking on the door. (Gina, midwife and mother)

I always use the analogy of, you know when you... when you want those yummy hormones to work, sometimes when you feel like you’re on stage, you get stage fright and they don’t work so well. So making someone feel a little bit more private and quiet, and not observed is why I turned the lights out [laughter], and to make her a bit calmer. (Danika, midwife)

Sometimes it was easier to remove the mother from the birth room in order to gain some aloneness. In Chapter 5, mothers talked about how they retreated to
the toilet or the bathroom during labour. Midwives also actively encouraged mothers to go to the toilet for a number of reasons during labour. Going to the toilet could assist the physiology of birth by emptying the bladder or bowels; and create more space in the pelvis through movement and upright sitting:

And just by getting her up, getting that little, little walk to the toilet and whether it’s the movement in the pelvis, the sitting, I don’t know but it, it seems to either declare one way or another that we’re really close, so… (Becky, midwife)

In addition, being in the bathroom provided privacy. “Yeah and it gives them the chance to hide away as well” (Becky). Midwives also noticed that women often took themselves away to the toilet in order to be alone:

Um retreat is something that comes quite often. They want to go to the bathroom, or go some place and be alone, and then they call out when they’re ready for someone to be with them, and support them with what’s next… Generally as the baby’s crowning [laughter] … (Faye, midwife)

The midwives’ practice reflected mothers’ need to minimise distractions. Midwives managed distractions for them, or assisted mothers to ‘retreat’ from distractions.

Managing external distractions required more effort in a hospital environment, and midwives expressed their frustration at the interruptions inherent in the hospital setting:

…but certainly in the private system you’ve got a doctor that flies in and flies out. And it completely changes the whole dynamics of the room. So you might have everything going really, really quietly, and you know nice dim lights, and you know just be doing beautifully. And then somebody walks in. I mean even if it's a knock at the door from one of your colleagues saying, ‘can you just check some syntometrine with me’… (Isla, midwife)
I can't stand it when a midwife will come to the door and open it and say, ‘are you in there?’ Or, you know [laughter] and ‘piss off!’ (Gina, midwife and mother)

Gina described how distracting a labouring mother could “rip em out of their labour land” pulling their focus from within themselves to “what everybody else is doing in the room.” In a home setting it was easier to manage distractions, Julia compared her experiences of attending hospital and homebirths:

You know it’s very different in the system... all their senses are heightened so any smell that you and I could smell, they can smell and doubly. And any, you know energy from people that we think is not good, then they can feel it doubly not good. So, it just interrupts the whole physiological process, yeah. I've seen it happen a thousand, million times, yeah. (Julia, midwife)

**Internal distractions**

In Chapter 5, mothers described how internal distractions were caused by unhelpful thoughts and emotions. Midwives also recognised how internal distractions could influence a woman’s experience of birth. Becky (midwife) talked about how support people could trigger internal distractions:

So it’s really important I think, people don’t understand... as in clients don’t understand the importance of them choosing their support people really well. And if there’s any sort of tension in the room it’s not gonna do the mother any favours at all, as they say adrenalin’s very contagious. And you know that’s the last thing we need in the room. (Becky, midwife)

Midwives knew that internal distractions could influence the birth process and attempted to help women when any arose during labour. Helen talked about attending the birth of a mother who had previously experienced a long labour ending in a forceps delivery. She felt that the mother was distracted by emotions relating to her previous birth and was holding back:

And she just said you know, ‘when is this baby going to come?’ And I said, ‘well when you let it come.’ Then she said, ‘well what do you mean, when you let it come?’ And I said, ‘well I just
wonder if maybe you’re stopping the baby coming, or you’re worried about something.’ I said, ‘this is a different birth than last time, it’s doing... you’re doing fine.’ I said, ‘I think this baby’s probably been ready to come for some time, but you’re not ready for it to come.’ And the husband immediately kind of, he got totally what I was on about... And he said, ‘are you scared of something?’ And she just looked at him and said, ‘well I don’t think I’m ready yet, it can’t be this quick.’ And I said, ‘well that’s just... you’re probably comparing it again to last time, and it can be that quick.’ And I said, ‘maybe you’re different this time than you were last time.’ (Helen, midwife)

Eventually the woman responded to Helen’s reassurance and “it was probably only 3 contractions and the head was out.”

As discussed in the previous chapter, mothers mostly talked about clearing internal distractions before labour began. Midwives who were able to develop a relationship with mothers in pregnancy were able to assist them to do this. For example, Andrea shared an example of assisting a mother to clear internal distractions in pregnancy, and again in labour. In her first labour the woman had been given an episiotomy without consent, which she had found very traumatic. As she prepared for her second birth, Andrea was able to assist her to debrief:

...this is just a prime example of how... what the benefits are of having that continuity. So, for them last few weeks of pregnancy I visited her more than was clinically needed, for her psychosocial needs. And to work through that previous experience... I set about purposely debriefing her, I guess. I needed to remove that fear of what happened last time, and I needed her to trust me. (Andrea, midwife)

Although Andrea and the mother worked to clear the fear and emotions attached to the previous birth experience, they arose again during labour. Andrea was able to recognise this and assist the mother to clear her internal distractions by giving her space:

She probably got out of the pool at about 7, and she went to the toilet, and then she just laid on the floor. And her contractions went completely off I guess... that’s probably not the right
Midwifery practice: rites of passage

After around two hours:

“...she started to contract and her labour became quite powerful again” (Andrea, midwife).

The ability of internal distractions to disrupt labour contractions and progress was expressed by both mothers and midwives in the study. Both groups talked about how they sought to minimise distractions emerging from the environment or from within the woman.

**Being with**

Whilst mothers focussed within and shut out the external world during labour, they also wanted their midwife’s presence as labour progressed. This was particularly evident in the narratives of the homebirth mothers who had built up a relationship with their midwife during pregnancy. Emma talked about how she needed her midwife there in order to labour:

I was having strong contractions and I called her and said, ‘come because I need you to be here to fully go into the labour’ (Emma, mother)

…it was quite funny because I actually held the labour stationary while I waited for her arrive… And she arrived
silently, didn’t even say hello, it was just like her presence suddenly filled the room. And I knew she was there, and I just let my body go then, cos like I’d been holding on until she got there. And as soon as I got in the bath and I heard her come down the drive way it’s just like my body immediately just stepped up the pace and I was having 3 minutely contractions. (Emma, mother)

Genevieve also talked about needing her midwife’s presence during her first labour. Her midwife was reluctant to come so Genevieve told her partner to ring and “tell her I feel things in my bum, like I want her here.” When her midwife arrived, “she’s like ‘hmmm don’t think you are really feeling things in your bum‘”. Genevieve knew that by telling her midwife that she felt pressure in her bottom, her midwife would assume she might be close to birthing and attend.

For Clare, knowing her midwives were present helped her to focus inward.

You know and I just opened my eyes every now and then and I saw my midwives just sitting there watching me. I knew them, they knew me, it was all good. I just closed my eyes again and knew where [partner] was and... then you know just noticed what they’re doing, and concentrate on myself. (Clare, mother)

Midwives also talked about the importance of their presence for women. For example, Helen felt that women needed to know that she was ‘there with the birth’:

I think it’s really important to help them um feel safe with me around. That I am actually there, I’m not... you know I’m actually there in the labour with them. I’m actually connected with them in it. It’s not just a job, it’s... I’m there with the birth. (Helen, midwife)

Faye described a conversation she’d had with a mother about how her midwifery presence had influenced the birth experience, the mother told Faye:

‘When you walked in I knew I could have my baby with you.’ She said, ‘all night I knew I couldn’t have my baby with that woman’, that was the other midwife, ‘she smokes and that just
doesn’t go with me, it was on her breath, and I just couldn’t open myself to birth with her all night.’ And she said, ‘I just couldn’t think I could go any more that’s why I asked for the epidural. And when you walked in, I knew I didn’t need the epidural and I knew that I could birth my baby.’ (Faye, midwife)

Presence for the mothers and midwives did not necessarily mean being physically in the same room. For example, Belinda wanted her midwife to be at her home, but not in the same room until the end of labour. As discussed previously, mothers often physically removed themselves from the distraction of other people, including their midwife. Presence appeared to be about being available physically and emotionally to the labouring woman without intruding into her ‘own world’.

**Assisting reintegration**

In the previous chapter, mothers described how they reintegrated back into society progressively after birth. Midwives assisted with this reintegration by managing the reintroduction of the external world. Firstly, mother and baby became integrated with each other. Midwives supported this by encouraging skin-to-skin contact and early breastfeeding immediately following birth. Next, mother and baby reintegrated with the father and/or close relatives in the birth room. Midwives in my study talked about assisting this by providing space and privacy, often by leaving the room. For example, Becky expressed how important this time was, and how she encouraged fathers to be involved:

And you know trying not to rush mums and dads. Cos you know that time with their new baby is just so precious. You know I can’t take that time, turn back the time and reinvent it or anything else. So it’s really important that they have that bonding, that first hour of not being rushed at all… And you know getting the dads involved as well, not necessarily taking the baby off mum… but just getting them to hold baby’s hand or you know just chatting away to the bubby as well. Letting them know that their hearing is really acute, that they know your voice, and watch, you know see what bubby’s doing when you’re actually chatting to your baby. You know they’re actually
Julia described how she encouraged a father to bring the baby back to the mother after resuscitation.

And so they’ve got this baby on the resuscitaire and I’m having a look and it’s fine. And I said to dad, ‘go and get your baby, right now, go and get your baby.’ So he walked over and he pushed them away, and he picked up the baby and he took it, and he took his shirt off, and he’s got this baby, holding it skin to skin to himself. I thought, ‘you’re beautiful.’ And he walks over with the baby and he hands it to [mother], and so she’s got the baby. And like it was, it was amazing how fast we could actually get that unit back together. (Julia, midwife)

Julia, like Becky, recognised the importance of the mother-baby-father unit being together immediately after birth. Isla also talked about protecting reintegration by delaying medical involvement when she realised a baby had Down Syndrome. The birth story Isla shared was of a birth she attended during the night of a baby who unexpectedly had Down Syndrome:

This baby was breathing, um pink, everything was all right. This baby had gone to the breast and by this time it had had it’s bowels open and done all that a baby would normally do...
However, the mum and dad just hadn’t noticed anything… (Isla, midwife)

Isla decided to wait until the morning to alert the paediatrician because getting him immediately involved would have “spoil it everything”. The mother later told Isla she was grateful for having the opportunity to get to know her baby before dealing with the diagnosis.

In a hospital setting there were clearer distinctions between the steps involved in progressive reintegration after the initial mother-baby-father period. The new family would stay in the birth suite for a period of time. Next they would be moved to the postnatal ward, where close family members and friends would visit. This reintegration would be managed by visiting times, and in some cases institutional rules regarding the number of visitors. Eventually the woman and baby would be
discharged from hospital to reintegrate with society. However, in a home setting the midwife had less control regarding who was in the home around the time of the birth. Andrea talked about how she managed reintegration following a homebirth:

She fed her baby, I basically then just tidied up a bit, herded everybody out the room, and left her down there with her partner and told him to yell if he wanted me. Cos I felt from a midwifery perspective that they needed that time, there was mum there, there was lots of other people there and… But, you know I just like to protect their space too. So, I kind of you know got people upstairs out the way, and left them there on their own for a little while to spend a little bit of time with their baby. (Andrea, midwife)

Alternatively, Genevieve felt that her midwife over-estimated her need to reintegrate with her family after her homebirth. Genevieve’s parents lived near by and arrived at her home before the placenta had been delivered.

…this is probably, yeah the only one thing that I kind of regret about this birth… and um [midwife 2] was like, ‘oh do you want me to just help you, pull it out’, and I was like, ‘oh whatever’ kind of thing. And um, which she did, which like… and I just look back and I think, I don’t really need… you know why did you need to do that? Like there wasn’t really any problem. And she said ‘oh you know, your Mum and Dad were outside, I thought you just wanted it over and done with’. (Genevieve, mother)

NURTURING SELF-TRUST AND INNER WISDOM

Mothers in the study talked about how they cultivated self-trust during pregnancy and relied on their inner wisdom during labour. Midwives nurtured women’s self-trust and inner wisdom, and conveyed their belief in the woman’s capacity to birth. Actions and words that nurtured and asserted the mother as the expert in the birth process were a feature of every narrative in the study.
Reinforcing self-trust

Midwives balanced gentle encouragement with mothers’ need for minimal distraction. For example, Anna and Danielle described their midwives’ gentle and non-intrusive approach to encouragement:

I mean she [midwife] was very encouraging, saying yes, you know you’re doing well, you know just being really encouraging. But not... sort of talking all the time, sort of you know... in between contractions it was just very quiet and then when the contraction was almost over, she was just saying encouraging things, you know... ‘oh you’re doing really well’, yep. (Anna, mother)

...but she just told me that I was doing really well, you know just keep doing what you’re doing. She was really not, like she was there but she wasn’t you know full on in my face type there. She was really good. (Danielle, mother)

Encouragement centred around reinforcing self-trust and the essence of the message transmitted to women was ‘you can do it yourself’:

And just encouraging her that she’s doing a great job. You know she’s just amazing and the baby’s moving down beautifully, you’re going to be meeting your little one soon and all those really nice sort of encouraging types of things. (Becky, midwife)

Isla only offered encouragement and reassurance if the mother appeared to need it because she felt it was important to stay in the background unless needed:

And obviously if the mum’s getting very distressed and worried or anxious and what have you, I’ll just say something to soothe her or calm her. (Isla, midwife)

In Chapter 5, mothers described a time in their labour where they experienced self-doubt and felt overwhelmed. Midwives also identified that this was common for women during labour and usually close to the birth:
And then they change, you know as they get to fully [dilated] and so often they say ‘I can’t do this anymore, I want to go home.’ (Isla, midwife)

…they realise that there’s no control, and they kind of have a bit of a panic attack about that, a bit of anxiety and ah, but it passes very quickly, yeah… that’s a common thread I think, yeah. (Julia, midwife)

…you know they get quite like, ‘God what’s happening to me!’ you know. It’s like that out of control feeling. And I just went ‘whoah you’re doing really well’. (Carol, midwife)

At this point midwives described reaching out to the mother with reassurance. Mother’s also talked about their midwives providing reassurance to them:

…she basically did all the right things. She didn’t come in and freak out on me, she came in and did what I needed… ‘you know what to do, surrender to it, talk yourself through it and you’ll be right’, and cos everything else was fine and yeah, straight away all she needed to do was tell me that. I just needed to know it was normal, that there was nothing bad happening [laughter]… and so once she’d done that I was fine. (Belinda, mother)

Danielle also described how her midwife reached out to her when she was crying in the shower:

…and she was like you know you can do this, and just really supportive and stuff. (Danielle, mother)

Only one story, Emma’s, involved an active withdrawal of support at this point in labour, and interestingly, she considered this experience to be deeply empowering. At the end of her fourth birth she described asking her midwife to help her:

…as the pushing hit me it was like these bolts of energy just hit my head and travelled straight down my body, and straight through my cervix and she just followed it through. I’ve never experienced that with any of them, and the noises I made were
quite disturbing. It was like an entity from out of my body had come into me, like I’d been possessed by something. And I just gurgled in the back of my throat and I threw my head back and because this energy... it was like universal energy just came... [midwife] was in front of me and I said, ‘ohh [name] help me!’ it was just like ‘ahrgghh’. And you know I couldn’t sort of talk but I sort of groaned it out... (Emma, mother)

Emma’s midwife physically moved out of her view:

… and she moved out of my way so I couldn’t see her. She moved away! And I was like ahhhh, it was like all of a sudden it forced me to be into myself and to do it myself. It was really quite odd, it was almost like I tried to escape it. And I have no idea, I think she was behind, at my side and… so it was just me, it was literally like it was just me on my own. And that was the first time I’ve had that sensation, that it was just me there. (Emma, mother)

Emma gave birth in her bath and picked up her baby:

And then after a while, and it wasn’t straight away it was after a while, maybe three or four minutes [midwife] then came back into my view. And that was really profound what she did. (Emma, mother)

On reflection Emma felt that her midwife’s actions reinforced her self-trust and inner wisdom:

… after having experienced other people being in my view with my other labours, I think that that actually is probably a good thing for a birthing mother at that point... for nobody to be in her vision, if she’s looking. It just, it had such an overwhelmingly positive powerful effect on me. I can see why women freebirth, I think there’s something more instinctual about that than meets the eye, that we’ve lost. (Emma, mother)
Reflecting inner wisdom at work

Mothers described experiencing an overwhelming urge to push as the birth of their baby became imminent (see Chapter 5). At this point midwives encouraged them to allow their inner wisdom to work. They focussed the mother’s senses onto her body, encouraging her to listen, watch and feel her body:

I might say to them, ‘just listen to your body, let your body tell you what to do, and go with it. Whatever you’re feeling, go with it.’ (Isla, midwife)

And I really emphasise the importance of listening to what your body needs you to do… (Becky, midwife)

Two first time mothers described how their midwives encouraged them to listen to their body when they got the urge to push:

…and when I said I wanted to push, she said, ‘well you just do what your body’s telling you to do.’ (Danielle, mother)

And um yeah but they just said, ‘go with what your body is telling you, that’s the best indication’… (Florence, mother)

In some cases midwives used a mirror to show mothers their body working to birth their baby. Florence (mother) described her experience of watching her baby’s head crown:

And yeah just to see a little head crowning out, I was like ‘ah that’s amazing’, I thought it’d really scare me [laughter]. But no it was nice to see in the mirror and sort of see the progress with the mirror, that was cool. I just watched the part by part, and then [midwife] would go, ‘do you wanna look’, and I’d go, ‘ok’, and just rock backwards and she’d show me… ‘look how far you’ve gone’, and I’m like, ‘oh wow’, and she’s like, ‘you’re so close’… (Florence, mother)

Faye talked about using a mirror to reinforce the ability to birth for a mother, and the doctor who wanted to perform a vacuum extraction:

And I said, ‘OK your next surge is about to start now, here’s a mirror. I want you to have a look in the mirror cos you haven’t
seen how well you’ve been doing yet. And show your doctor here how well you’re doing and how close your baby is to being born.’ (Faye, mother)

Midwives used mirrors to reflect the mother’s body birthing, and to reinforce the mother as the active participant in the birth process.

In addition to encouraging mothers to watch, midwives also encouraged them to touch their body and baby during birth. Anna talked about how her midwife told her she could touch her baby’s head:

I think at one point… well there was a mirror there, so she was saying oh you know you can see your baby’s head now and…you know put your hand down and you can um you know touch it and feel it… (Anna, mother)

Becky suggested to a mother that she felt her own bulging forewaters:

And letting her know that if you want to touch those fore-waters see what it feels like. I’ve got a mirror there, using that but you know she wasn’t wanting to look that time at all. (Becky, midwife)

Emma’s midwife even suggested that she manipulated her own cervix:

And she said, ‘yes I think you’ve got an anterior lip of cervix’. So we discussed it and I said I’d have a feel, and I had a feel and I could feel it on his head, right on the front. And it was stretched really thin, it was like a rubber band… And, [midwife] explained to me to just keep my finger on it, with the next contraction to push, which I did and it went. (Emma, mother)

Midwives encouraged mothers to experience their inner wisdom at work using their senses. They reinforced women’s inner wisdom by conveying their belief in her ability to birth.
RITES OF PASSAGE

The findings presented in this chapter focus on midwifery practices during birth that support women’s experience of the childbirth rite of passage. Within the explanatory framework, these practices are the ‘rites of passage’; the rituals performed to assist women during their transition into motherhood. For the purpose of this thesis, Davis-Floyd’s (2003, p. 8) definition of a ritual will be used: ‘A ritual is a patterned, repetitive, and symbolic enactment of a cultural belief or value…’ Enactment of a ritual includes what is shown, what is said and what is done.

The ritual nature of midwifery practice

The use of ritual has been an integral feature of human life across history and cultures (Pickering 1974). The word ‘ritual’ originates in the Sanskrit ‘rta’ which refers to both ‘art’ and ‘order’, and ritual aims to create a sense of order and control during times of instability (Heinze 2000). The performance of ritual has been associated with a reduction in anxiety (Homans 1941; Malinowski & Redfield 1948). Therefore, rituals assist in minimising the anxiety associated with unstable and uncontrollable life events such as birth. I acknowledge that many midwives may not consider what they do and say as ritualistic. However, I consider any practice (words and actions) commonly or routinely carried out during labour to be ritualistic. This is in keeping with other researchers who have used rites of passage as a framework for exploring the childbirth rite of passage (Cheyney 2011; Davis-Floyd 2003; Machin & Scamell 1997; McCallum & Reis 2005; Seel 1986).

As Seel (1986) points out, labeling a practice as a ‘ritual’ is not a criticism of that practice. Rituals can cushion the disturbance of transition and be affirmative for the person undergoing change (van Gennep 1909/1960). For example, the rituals the midwives in my study performed to tend the boundaries of aloneness by dimming lights, closing doors, and assisting women to retreat. Or the repetitive use of words such as ‘trust your body’ used to reinforce self-trust and inner wisdom. In addition, Kitzinger (2005) argues that rituals during childbirth can transform personal and social relationships, bonding women together and creating social harmony. It can be argued that the rites of passage midwives performed for women during birth assisted in sustaining the mother-midwife relationship.
The midwife as a ritual companion

Turner (1967, 1987) noted that important members of the social group such as Elders or Shaman often guide a person through the liminal phase of a rite of passage; he called these guides ‘instructors’. The instructor’s role is to perform rituals that reflect the unstructured nature of the liminal state; reflect the new state the person will join; and reflect the axiomatic values of society. It can be argued that midwives take on the role of ‘instructor’ in their relationships with mothers. Whilst the strongly authoritative nature of Turner’s ‘instructor’ is not an expectation of the mother-midwife relationship, the provision of guidance and support is (Australian Nursing and Midwifery Council 2006). The midwives in my study provided encouragement and reassurance rather than instructions. It can be argued that their role was more of a ‘companion’ on the birth journey rather than an instructor. The definition of a ‘companion’ is ‘a person, usually a woman, employed to be with or help’ (The Macquarie Dictionary 2010, p. 166), which better reflects the relationship mothers and midwives described in their narratives. The midwives provided a presence for women by ‘being with’ them and meeting their needs during their experience of birth.

The mother-midwife relationship is also highly structured in terms of roles and expectations during the childbearing experience. Structural relationships are triggered and enhanced by ritual, and Kruckman (2000) suggests that prescribed visits and routine practices during pregnancy, birth and in the postnatal period activate the mother-midwife relationship and reinforce its structure. It can be argued that this structured relationship exists even in the absence of continuity of carer. Every encounter between a midwife and a mother occurs within socially and professionally determined boundaries. Both midwives and mothers in my study had assumptions and expectations about the mother-midwife relationship based on social and professional structures.

Turner (1987) suggests that the passivity of the person undergoing a rite of passage to their instructor, and their malleability is increased during the liminal phase. Davis-Floyd (2003, p. 19) also considers the liminal phase to be a time of susceptibility:

One of the chief characteristics of this liminal, or transitional period of any rite of passage is the gradual psychological ‘opening’ of the initiates to profound interior change.
During labour a mother is in a particularly vulnerable and open state. The previous chapter presented findings regarding the altered state of consciousness that mothers experience during labour where they are ‘in their own world’, deeply focused within. Anderson (2010) argues that in this altered state, the power of surrounding people and their messages can be irresistible. Both mothers and midwives in my study were aware of the power of people in the birthing environment. Midwives sought to manage their own, and others interactions with the labouring woman. Mothers expressed their vulnerability to their own midwives suggestions, for example, Anna (mother) stated: “I was totally in the zone at that time, so I was really just, you know, what ever she said to do... that’s what we were going to do.” Ludwig (1966) identified hypersuggestibility as a characteristic of most altered states of consciousness. In addition, he noted that people in altered states of consciousness demonstrate an increased tendency to accept suggestions from authority figures; these suggestions are also imbued with greater importance and significance. Therefore, the altered state of consciousness associated with labour results in a mind that is conducive for ritual (Davis-Floyd 2003). Rituals performed during the liminal phase can have a powerful and long lasting effect. Women remember what was said and done during their birth experience with great clarity years after the experience (Simpkin 1991; 1992).

Rituals reveal and reflect both interior processes and deep cultural values (Wilson 1954). Midwives in my study performed rites of passage that were aligned with women’s needs during the childbirth rite of passage. They assisted mothers to create an environment with minimal disturbances so that they could focus within. They reinforced mothers as the experts in their labour by encouraging them to trust their bodies. It can be argued that self-confidence and trust in oneself are important attributes for the role of mothering which follows birth. The cultural values reflected in the rites midwives enacted were aligned with a holistic and humanistic approach to birth (Davis-Floyd 2001), and with the international midwifery philosophy of care whereby the woman is central, and is an expert regarding her own body, baby and birth (International Confederation of Midwives 2010). Both mothers and midwives valued the contribution that the rites of passage made to the birth experience.
CONCLUSION

This chapter presented findings about midwifery practices during birth that were aligned with women's experience of birth. The explanatory framework was applied to conceptualise these practices as rites of passage. The following chapter will examine midwifery practices that are contradictory to the rites of passage, and are not necessarily aligned with women's needs.
Chapter 7

Midwifery practice: rites of protection

...and doing the balotting, you know I, I never find that easy or comfortable... I know it’s a necessary evil, I guess if you want to call it that. But you know everyone wants to know... And I mean, yes that can be useful in that whole monitoring process, but I still find it, it’s all really invasive. I just, yeah I never feel totally comfortable with it, I never have done, and I still don’t. (Edith, midwife)

INTRODUCTION

This chapter presents findings about midwifery practices that were in contrast to the rites of passage discussed in the previous chapter. It discusses routine
clinical assessments of the woman, her baby, and labour progress and how they could disrupt the synergy between midwifery practice and mothers’ experiences of birth. Like the previous chapter, the quotes are mostly from midwives, but mothers’ perspectives of midwifery practice are also included. Two core themes emerged from the data ‘disrupting aloneness’ and ‘undermining self-trust and inner wisdom’ (see Figure 4). These themes are in direct contrast with the themes identified in the previous chapter relating to midwifery practice. This chapter will discuss these contradictory themes and subthemes, and how they represent a discord in practice approach. Finally the explanatory framework of rites of passage will be applied to conceptualise these practices as ‘rites of protection’.

**DISRUPTING ALONENESS**

Women’s experience of birth involved focussing within and shutting out the distractions of the external world, and midwives supported this by assisting them to manage these distractions. However, midwives also performed clinical assessments on mothers that required disturbing them. For example, Gina talked about the difficulties of finding and auscultating the fetal heart rate when a mother was in an all fours position:

…and I find it [auscultating the fetal heart] really hinders her birth too. It’s really distracting for them, sometimes they’re more focussed on that than what else is going on, you know, than the push… and in hospital when you’re trying to do it each contraction… poor women [laughter], poor baby. (Gina, midwife and mother)

Helen worked in a hospital with a policy of electronic fetal monitoring with a cardiotocograph machine for all women during labour. The hospital had telemetry monitoring so that women could be mobile and use warm water immersion:

…sometimes positioning in it is difficult when they change their position, you’ve got to fiddle with the belts and things. So it spoils the atmosphere, I don’t like that. (Helen, midwife)

Mothers also described clinical assessments as being uncomfortable and distracting:
And the midwife annoyed me a bit cos she tried to take my blood pressure when I was having a contraction, and I would go, ‘go away, go away.’ (Hillary, mother)

I just hated it, it interrupted the whole contraction cycle because I couldn’t move, or the intensity of the contractions would become overwhelming. So to actually move so that the Doppler could be used was not my thing. (Emma, mother)

Then the midwife came in and tried to do an exam just to make sure that the baby’s head was down… but I was sort of having contractions in between… so I found it really very uncomfortable to be lying down on the bed. I don’t understand how people ever give birth in that… like I, it was really… I was like, ‘oh I’ve just gotta get up, I’ve just gotta get up’, so it took a few minutes for her to actually be able to see that the baby’s head was down. (Anna, mother)

Some mothers described avoiding clinical assessments, for example, Belinda locked herself in the bathroom to avoid assessment during her second birth:

The first one I didn’t like it when the doctors came near me at all. It really upset me, and they wanted me to lie on my back to do examinations, it was horrendous. And that’s what I remember being the bit I hated about labour. So with the second one I literally locked myself in the bathroom and wouldn’t come out… it was a private hospital… until I knew she was crowning and then I came out of the bathroom [laughter]. They were banging on the door trying to get me out, ‘no no’… ‘we need to examine you’… ‘no I’m fine’. (Belinda, mother)

Again, retreating to the bathroom provides protection from others, a theme discussed in the previous chapters. Hillary took a more direct approach and asked her midwife to ‘go away’ when her midwife attempted to check her blood pressure.

Edith (midwife) talked about vaginal examinations (VEs) and abdominal palpation as being invasive:
You know I hate having to do VEs, I really hate it. I find it very invasive um you know just doing an abdo palp on some women is enough to... particularly when you’re checking to see where the head is in the pelvis and you’re doing that palp across the top of the symphysis... (Edith, midwife)

Vaginal examinations were a common feature of the midwives stories. However, seven of the mothers in the study did not experience this type of assessment at all during their labour. Three of the first time mothers remarked on the lack of a vaginal examination as an unexpected but positive aspect of their birth. For example, Anna was surprised by the lack of intervention she experienced during her labour in a private hospital:

And probably the lack of intervention I suppose. That was sort of surprising as well and really good. You know in a good way. In that there wasn’t people sort of you know, poking and prodding you and doing that sort of thing. That I was just getting on with having the birth, so I think that was good. Not having to have an internal examination, that was good [laughter]. (Anna, mother)

UNDERMINING SELF-TRUST AND INNER WISDOM

Chapter 5 discussed how important it was for mothers to trust their inner wisdom during labour; and Chapter 6 described how midwives supported mothers to do this. However, midwives also performed clinical assessments during labour in spite of the mother’s own knowledge. Above, Anna described how she was subjected to an uncomfortable palpation so that her midwife could identify her baby’s position. Anna already knew her baby was head down:

But, he’d been down for months and months and months before, I don’t think he was doing much flipping around in there [laughter]. (Anna, mother)

Mothers allowed their midwives to perform assessments despite their own knowledge about their baby’s well-being or labour progress:

And [midwife 2] was checking the heart beat every now and then, and I was like yeah who cares, it doesn’t matter, I know
everything’s fine. Cos I don’t know, I think you do, you just know that it’s OK. (Clare, mother)

I let her check the pulse [fetal heart rate] and everything when she first arrived to make sure… but I was really tuned in at that point, I would have known if there was anything wrong. (Belinda, mother)

And interestingly through the labour the monitoring I found completely invasive and unnecessary. I knew the baby was OK and it was completely pointless. (Emma, mother)

Jane’s midwife attempted to perform a vaginal examination to assess labour progress whilst Jane was pushing her baby out. Jane did not require confirmation that her labour was progressing:

And then [midwife] was trying to do an internal… had the mirror… was trying to see what was happening. And said ‘oh can you sit back on the bed cos I have to do an internal. And I said, ‘I can’t.’ And [midwife] said, ‘why?’ I said, ‘the baby just came out.’ And [midwife] went, ‘oh, yeah.’ (Jane, mother)

It seems that mothers allowed their midwives to carry out assessments despite finding them uncomfortable or unnecessary. This suggests that they were allowing assessments to be performed for the benefit of the midwife rather than for themselves. Jane’s midwife bargained with her regarding interventions and assessments. Jane knew that having a vaginal birth after a caesarean meant midwives would want to continuously monitor her baby’s heart rate. She wanted to be treated as a normal labouring woman, and did not want any additional precautions or monitoring. However, she found herself negotiating with her midwife and trading the insertion of a cannula for continuous fetal heart rate monitoring, neither of which she wanted:

And then the midwife said to me, ‘look I know you don’t want um the cannula, but they… if I just put it in they won’t, you know, they won’t sort of hassle.’ [Midwife] said, ‘I know you don’t want continuous monitoring, but I could negotiate for intermittent monitoring if you put the cannula in.’ Or whatever.
And I was just too out of it to care and I said, ‘oh all right.’ (Jane, mother)

Iola was not concerned about her baby’s well-being until her midwife struggled to find the fetal heart:

With [first child] the lady was fumbling… the midwife… And so she was looking for the heart beat, and I opened my eyes and I remember just seeing her kind of looking like with this bit of a concerned look on her face trying to find the heart beat. That was the only point where I thought, ‘huh, oh’, and then she found the heart beat and it was fine. (Iola, mother)

In this case the assessment raised concerns for Iola rather than reinforcing her knowledge regarding her baby’s well-being.

In contrast, three mothers found that clinical assessments provided reassurance and reinforced their self-trust. Two of the first time mothers were reassured by their midwives’ assessment of their baby’s heart rate:

I liked that [fetal heart rate auscultation] cos you can hear it on the microphone that they put on your tummy and you know, you know they’re always reassuring going, ‘nah that’s a good heart beat, no baby’s not stressed’. (Florence, mother)

I think it [fetal heart rate auscultation] was probably good for reassurance… But it was I guess reassuring for her to check and then go, ‘yep, it all sounds good.’ (Anna, mother)

Genevieve was the only participant to describe a vaginal examination as a reassuring assessment during her labour. She initially rejected her midwife’s offer to perform a vaginal examination, but eventually agreed. Her midwife reassured her that she had “plenty of room”, that her cervix was fully dilated and that the baby was moving down with contractions. This information helped Genevieve to trust her ability to give birth:

… cos it was probably about 3 hours that I was in that place of, ‘it’s not really going to come, this baby’s never actually gonna be born, you know this is just not going to happen, like it’s not gonna come out…’. Um so yeah, that knowledge was really
powerful. It really helped me. I was like, ‘yep, OK let’s do it’, and he was born probably an hour after we did that internal I think. (Genevieve, mother)

Therefore, for some mothers clinical assessments could confirm their inner wisdom and provide reassurance.

**REDIRECTING THE BIRTH JOURNEY**

In addition to disturbing the labouring woman and undermining her inner wisdom, clinical assessments could result in unnecessary interventions. These interventions could further disturb and undermine the woman, and even risk the well-being of mother and baby. Midwives were aware of this, and shared their experiences of redirecting birth journeys with clinical assessments. Intermittent auscultation of the fetal heart is a common routine clinical assessment performed by midwives during birth (see Chapter 2). Midwives talked about how identifying normal decelerations via auscultation often resulted in interventions. For example, Danika shared a story about a first time mother who was pushing her baby out:

…the baby’s heart rate went down to under 70 but it came back up again. But for some reason I had one of the more experienced midwives in the room um, and she heard the heart rate go down and kind of went into panic mode. And even though it came back up again she was, ‘right OK, we've got to push this baby out, we've got to push this baby out’, and I'm going, 'no, we've got to let the baby rest a little bit', cos you know the baby needs a bit of rest because it is coming up a bit slowly. And we, yeah and then she was in the room the whole time and we were pushing this baby out, and pushing this baby out, and you know we had [doctor] in there, and we were pulling this baby out. And it was just... they ended up with a... tentorial tear... And I know that that baby didn't need to be vacuumed out, I just know it didn’t, I know it didn’t, it didn’t need to be, but we turned it into that scenario and the baby was vacuumed... I was really disappointed with that management. Like I just, I knew... and I didn’t know how to stop it, it was happening and I wasn’t in control... (Danika, midwife)
Andrea had also witnessed this kind of response to normal physiological decelerations of the heart rate.

...one of the issues that I have is often in hospital you know in second stage, the heart rate will go, it will drop, that is what happens. Or if people ARM them, and carry on and then the heart rate drops, and then they all freak out, and then you know the woman's in lithotomy, and they're pulling it out and it comes out pink and screaming. Or they rush her for a Caesar and it's fine. (Andrea, midwife)

Gina thought the distraction involved in listening to the fetal heart could interfere with the mother's ability to push her baby out.

And then I guess it... when you think about it, it's almost a vicious circle isn't it, where you're doing that [auscultating the fetal heart] and it upsets their pushing, and they have a prolonged second stage, and the next minute you've got a doctor in the room pulling their baby out with a vacuum... (Gina, midwife and mother)

Vaginal examinations were also identified as an assessment that could redirect the birth journey. Edith shared an experience where she performed a vaginal examination and assessed the woman’s cervix to be fully dilated. She then encouraged the mother to push. While pushing the mother began to bleed and Edith asked an obstetrician to review the situation. The obstetrician performed a vaginal examination and found that the cervix was not fully dilated:

...and he [obstetrician] said, 'she's got to stop pushing.' OK I said, 'you stop her.' And he tried and she wouldn’t. So, we got the anaesthetist in and we gave her an epidural... And I felt really bad about that, and I went oh jeez [Edith] you're fingers aren't long enough. (Edith, midwife)

Edith questioned her own ability to perform a vaginal examination and felt responsible for getting the assessment “wrong”. Edith’s clinical assessment and direction to push based on her assessment redirected this mother’s birth towards an epidural.
Andrea did not perform vaginal examinations to confirm full cervical dilatation because she was aware that the findings could result in intervention:

...one of the issues I have is when people do examinations, in particular in hospitals and say, 'oh she's fully dilated', and then get them pushing. And they're exhausted cos they're pushing for an hour or two. Cos, you know in actual fact the physiology... the baby has to descend you know, you actually have a vagina, and the baby has to get from the cervix, down the vagina to the perineum... (Andrea, midwife)

Isla talked about how the findings of a vaginal examination could contradict the reassurance and encouragement previously given to a mother:

... you get somewhere and somebody's been having really good contractions and they're saying, 'oh I can't do this anymore.' You're thinking oh they must be transitional and, 'oh I'm gonna have to have an epidural at this point.' So you say, 'oh well, just let me examine you, I'm sure you must be coming up to fully.' And you find that they're 4 centimetres or something and it's soul destroying because you know you've kept saying to them, 'oh I'm sure you can't be going for much longer.' And then all of a sudden you're the biggest liar on the planet cos, 'you said it wasn't going to be much longer and I'm only 4 centimetres!' [laughter]. (Isla, midwife)

Midwives were also aware of the inaccuracy of cervical dilatation as an indication of future progress. For example, Isla went on to describe how labour could be unpredictable and difficult to assess:

...that can go the other way as well cos I've had that happen and I've gone out to the phone to ring the doctor and say you know, 'this lady needs an epidural.' And while I've been sat there she's suddenly gone, 'urrrghhhhh', and I've thought hang on, 'I'll ring you back.' And you've gone in, and there's a head there you know, sort of 20 minutes before you've examined her and she's been 4 centimetres, and all of a sudden there's a head there. Which text books say that it happens in 20
minutes? The unpredictability, totally unpredictability! (Isla, midwife)

Danika also noted how the findings of a vaginal examination did not provide reliable information about future labour progress. After a mother requested pethidine, Danika performed a vaginal examination as per hospital guideline and found the mother's cervix was, “about 5 or 6 centimetres.” She was unable to provide the mother with a definitive timeframe for birth, and the mother chose to have pethidine. The mother birthed soon after she had been given pethidine, before the medication had taken effect. Becky also described a similar scenario in her narrative. In these cases the mother is making the decision to take a medication based on an inaccurate clinical estimate of her future labour progress.

Another method routinely used to assess labour progress is monitoring contraction pattern, and again this assessment is imprecise. Carol explained how she monitored contractions during labour by putting her hand on the woman’s abdomen, “…so you can actually feel the contractions”, and assessing how often contractions occur and how long they last. This is consistent with descriptions of contraction assessment in midwifery text books (Johnson & Taylor 2010; Thorpe & Anderson 2010). However, Carol also talked about how unreliable this assessment could be:

But, I’m also very aware that pregnant women, or labouring women never go according to text books. So you know you can... someone with what you perceive as not very good contractions and they’re not acting very well and yet it’s doing all the work and their cervix is opening. And then you can have another woman who is getting fantastic strong, regular contractions and not getting anywhere. So, I just always keep my mind open to I guess not, not a textbook thing of what should happen, it’s so individual. (Carol, midwife)

Midwives performed clinical assessments knowing that the unreliable information they gathered could result in unnecessary interventions for the mother.
ASSESSING WITHOUT DISTURBING

Whilst every midwife in the study used clinical assessments, they also talked about how they assessed well-being and progress in ways that did not disturb the labouring woman. In particular midwives used observation to assess women in labour based on their previous experiences of women’s birthing behaviour. This embodied or grounded knowledge (Hunter 2008) arose from the midwife’s personal experience with labouring women. This method of assessment supported the woman’s need for minimal disturbance because it did not require ‘doing to’ the mother. Instead, midwives watched and listened, picking up on the subtle and not so subtle cues the mother’s behaviour communicated:

I would rather be guided by their behaviour. What they say, what they do, their sounds that they make. You know when they’re going through the normal, um you know first stage contractions and what have you, and their individual sounds. And then they change, you know as they get to fully, and so often they say, ‘I can’t do this anymore, I want to go home.’ And you sort of think they’re transitional, you know but that’s it, this baby’s not going to be too long. And then you hear that, ‘uurrgggggh’ [pushing noise] sound, now transcribe that one [laughter]… but it is. There’s a deep sort of guttural sound that they make. And you think ‘yup that’s it, this baby’s coming.’ And sometimes that’s all they do… You know that’s just something I’ve picked up over the years, as to what women say and how they behave and just their body language, the nuances that they make and stuff like that. (Isla, midwife)

Edith also described the characteristic non-verbal sounds mothers made during labour, “she was making those very characteristic noises of a woman who’s moving from first stage to second stage, which are pretty classic sounds that most midwives who’ve got a, even a little bit of experience will pick up on very quickly.” Midwives, in particular those who had attended homebirths noted that the birth environment could influence women’s labouring behaviour. Midwives considered that labouring at home allowed women to behave in a more natural and instinctive manner. This, along with a greater ability to focus on one woman in the home environment allowed midwives to assess women’s behavioural cues
more accurately. Julia talked about how attending birth in a home setting allowed her to become more of an observer:

…as an observer I think you can see a… yeah the performance really, that’s going on in front of me… at this stage of this performance what is it saying? And often I think it’s probably um… it’s not what she’s saying, it’s what she’s not saying. And it’s what she’s displaying, yeah the way she’s moving. Um the way she’s moving, what her body is doing in a physiological sense. So, if she’s um hot, cold, sweaty um all those kind of things, you know just observing her… in a natural setting like home um you can see that performance, and you can just watch that performance. And you can use your skills and your experience to be an observer more than anything… More of an observer than a doer I suppose, yeah, but observing is big. Whereas if you’re in the system there’s this tendency to do [laughter] and I find that that just interrupts that whole um play that sort of happens at home…. (Julia, midwife)

Andrea practised midwifery in homes and in hospital. At homebirths she was better able to observe the labour and did not use a partogram.

… I don’t complete a partogram at home. Because I’m there all the time with that woman and observing, and watching, and listening. (Andrea, midwife)

Whilst all of the midwives in my study used clinical assessments to gain knowledge about well-being and labour progress; they also talked about their use of intuition or described experiences that demonstrated the use of intuition:

I’ve been a midwife for 20 years and I’ve kind of worked in a lot of different areas… and I do use my instincts and intuitive nature a lot. And there’s not really any way of measuring it, and there’s sometimes no way of explaining it. And, I don’t know how… or what you’ll do with that information but… it’s not measurable. I can’t explain it with evidence… (Andrea, midwife)

Although Helen followed hospital policy regarding when to perform a vaginal examination, she indicated that her ‘gut feeling’ was of more importance.
So she’s been pushing for a while, and you haven’t had head on view then you do a VE just to check, just in case it’s an OP position or whatever. Um having said that, I have my own personal rules on it anyway. I think I have a gut feeling about it and that’s what I follow probably more than anything else… So I would go for my gut quite a lot. (Helen, midwife)

Danika described her interpretation of the fetal heart rate as a feeling:

And you can hear a heart rate that's OK, you can just hear it, you can feel it. One that's a bit low, you… you know like there’s a point where it doesn’t feel right or something. (Danika, midwife)

Having embodied experience of practising midwifery and attending births enabled the midwives to intuitively assess the situation. Andrea described how she was able to visualise and “feel” the baby during labour and birth.

And I guess that's how I practice, even when I do a palp I can visualise the baby. And I can't explain that either, but I can... I kind of visualise the baby and again for catching babies… I don't really need to look. I kind of can feel where they are, and I guess that comes over years of time, of being a midwife, I don’t know. (Andrea, midwife)

Midwives who had experience of providing continuity of care indicated there was a link between their connection to the woman and their use of intuition. Julia described how being in tune with the mother allowed her to notice any problems early:

… you’re in such, you know you're in tune with them so much that if something’s going a little bit off centre, then there’s plenty of time for discussion about what we’re going to do here. (Julia, midwife)

In her interview Andrea talked a lot about a “partnership” relationship with women, and how important this was for her practice. When talking about her use of intuition she said:
...I use it certainly with women that I look after in a continuity of care relationship I would say probably about 100% of the time. (Andrea, midwife)

TENDING THE NEEDS OF THE INSTITUTION

Midwives knew that performing clinical assessments could interfere with the mother's need for aloneness and could undermine her own knowledge. They also noted how inaccurate clinical assessments could be at predicting future labour progress or well-being; and they shared the alternative methods of assessment they used that did not disturb or undermine mothers. Routine, clinical assessments were not aligned with the midwives beliefs and philosophy about birth and midwifery practice. However, they expressed a need to perform clinical assessments to meet the needs of the institution. The definition of an 'institution' includes: 'an organisation or establishment for the promotion of a particular object... a building used for such work... an organised pattern of group behaviour, well established and accepted as a fundamental part of a culture... any established law, custom, etc.' (The Maquarie Dictionary 2010, p. 433). My use of the term refers to the institution in which midwifery practice takes place for example, the medical and obstetric paradigm; the hospital culture; workplace guidelines and policies; midwifery regulatory bodies; and the established customs and expected practices.

Midwifery practice was influenced by the need to meet the needs of the institution. For example, Danika described how she asked mothers to move in order to auscultate the fetal heart rate, and reflected on her need to do so:

I will ask women to move if I just can't feel it. If I can't hear it um I'll get them to sit back on all fours and try and find it... Or get them to lift a leg and try... like I'll work to find it... Yeah and as much as I can I'll try and work around them. I mean if I just can't hear it, I have to hear it. You know I guess I'm a little bit paranoid about not hearing it. Only because it's, you know how I've, I guess been trained... when I know I need to check it, I need to check it, you know like I can't just go oh no I just won't listen. (Danika, midwife)
Here Danika clearly expresses her own need to hear the fetal heart rate, and she
does not talk about whether the mother needs to hear it. Edith described
performing clinical assessments as a “necessary evil”, something she needs to
do, even though she acknowledged that it was “really invasive” for the mother.

... I guess I know I've gotta put my hands on and yes I know I
have to check to see, generally speaking where that baby is in
relation to the mother's spine etc, etc, and then you've gotta do
the fetal heart and all that stuff. (Edith, midwife)

Performing for an audience

Midwives talked about how they were “supposed” to perform assessments. They
felt that they were being watched and were required to perform in a way that met
the expectations of the institution. For example, carrying out clinical assessments
was an expectation of working in the hospital:

...in the hospital you're supposed to do it aren't you [laughter]...
I guess with your policies and procedures you are bound to do
those things that, yeah. It would be nice to be able to just make
them up sometimes but you can't can you [laughter]. (Gina,
midwife and mother)

Carol reflected on how not listening to the fetal heart during the “second stage”
would avoid hearing decelerations:

...we're supposed to take the heart rate after every contraction
and it can be quite tricky in second stage... No we wouldn't [get
away with not listening], we wouldn't. But you just think a lot of
things we wouldn't hear. (Carol, midwife)

Danika described not listening to the fetal heart as per hospital policy as
“naughty”:

I don't [listen], it's quite naughty. Sometimes in that position [all
fours] because there's a bit of movement and stuff going
around, I don't listen for a full minute. (Danika, midwife)

Becky admitted that listening to the fetal heart rate was defensive:
So I guess because we weren’t sure what sort of colour the fluid was round the bubby at that time, it’s more one of those defensive type things that you tend to do, that just show that you are monitoring. (Becky, midwife)

Becky protected herself by providing evidence that she was performing as expected. Andrea talked explicitly about how her practice was different in a hospital setting compared to at a homebirth:

I probably would listen to the baby more frequently because that is expected policy. And the policy is obviously a partogram and all that sort of thing, it's much more rigid, it's not about the woman, it's about protecting from litigation and all that sort of thing. So, my practice would probably be modified within those systems.... (Andrea, midwife)

As previously discussed, midwives used other ways of assessing women’s labour such as observing their behaviour. These methods were in keeping with a holistic and relationship-based approach to midwifery care. However, the midwives were aware that these forms of knowledge were not valued or understood by the institution. For example, Andrea knew that the intuitive midwifery she practised in a homebirth setting would not be accepted within the hospital.

…I kind of didn’t do any examinations but I kind of, I think from experience, intuition, I don’t know. And I suppose the medical colleagues will go, 'huh, huh, load of rubbish’. (Andrea, midwife)

In their narratives, midwives expressed a sense of being observed and monitored, and they adjusted their practice to protect themselves against the consequences of not meeting the needs of the institution. They described working under indirect and direct surveillance from obstetricians.

*Indirect surveillance*

Midwives were expected to meet the needs of obstetricians who were usually outside of the birth room. Becky talked about keeping the doctors involved:

Certainly as far as keeping doctors involved… there’s certainly a guideline there to say that after an hour of active pushing if there’s no progress, we need to notify the doctors. And for a
multi its half an hour, which is fair enough and I certainly am happy to do that. But, I... some of the doctors tend to want to come in unnecessarily and want to intervene unnecessarily...

(Becky, midwife)

Becky was aware that informing the obstetrician could result in unnecessary intervention, but still did so. Edith described how midwifery practice changed depending upon which obstetrician was observing:

...we’ve got one female consultant at [hospital] who’s very generous on second stage um active pushing and will let a primip go for 2 hours, and a multi go for 1... which is twice the usual amount... So when you know she’s on, interestingly our midwifery practice changes, yes it’s very interesting. ‘Who’s the consultant on tonight?’ ‘Oh right OK good so we know we’ve got a greater margin for active pushing and also doing other things with either primips or multis’. (Edith, midwife)

Edith also described how another obstetrician was “…right into timelines and draws the lines on the frigging partogram.” She performed vaginal examinations to meet the needs of this obstetrician, “…because I found out the hard way that if you don’t do it, then you haven’t got the timeline there” (Edith). Alternatively, Helen described how the policies and protocols in her hospital were open for discussion:

…and even though we have policies and protocols, things are still open for discussion. As long as you’re careful to kind of think it through and get the support of the obstetrician. The obstetricians are very supportive of a lot of flexibility, as long as they’re informed of what’s going on if you’re going outside the normal parameters... But not being informed, that’s what they don’t like. So, and that’s OK cos they have ultimate responsibility. (Helen, midwife)

Flexibility required the support of the obstetrician, which relied on the midwives sharing information. As Helen noted, the ultimate responsibility for the safety of the mother and baby was considered to rest with the obstetrician. The midwife’s role was to gather information using clinical assessments and keep the obstetricians informed.
Direct surveillance

In a hospital setting it was common for members of staff to enter the birth room during labour, and this interruption could disturb the labouring woman. Entering the birth room also allowed the midwife's practice to be directly watched over and influenced. Becky described how an obstetrician entered the birth room as she supported a mother pushing:

…I didn’t want to break the waters, she [the mother] didn’t want me to break the waters. And we’d talked about that earlier… the doctor happened to pop her head in at this point. ‘What are those membranes still doing there? Why don't you break them?’ I just ushered her away without sort of saying anything. (Becky, midwife)

The obstetrician not only entered the birth room uninvited, but also questioned the scene she encountered. Faye shared an example of how her practice was monitored and influenced within the hospital system. Faye was known to the staff as a homebirth midwife, and she felt that her approach to midwifery care singled her out for additional surveillance when she worked in the hospital. The mother she was caring for was not progressing according to hospital timelines and the midwife in charge told Faye to start a syntocinon infusion. Faye explained the hospital policy to the mother who declined augmentation. Later, whilst Faye was on her break the obstetric team entered the birth room and performed a vaginal examination, “I've just noticed when I've been in there quite a lot of times, doctor teams seem to go in when I'm not there somehow...” The mother agreed to augmentation whilst Faye was absent:

…she had accepted just the drip but not the epidural. And I knew very well that she’d accepted it trying to keep the peace between the hospital, not because she wanted it... Anyway, I respect that a protocol’s a protocol. (Faye, midwife)

Later the doctors returned to continue their monitoring of the labour progress and perform another vaginal examination. The mother's cervix was fully dilated but she did not have an urge to push. Faye understood that this was because, “bubby was still descending, it was still doing that elasticising, and doing all those deep stretch receptors in her very strong fit body.” Despite knowing that this was normal, Faye changed her usual practice to fit the needs of the obstetricians:
And I knew that we had a very unhappy team of doctors and midwives outside the room, so did what I could to encourage her to push, and really push with her surges. Because although it’s not my way of birthing, I knew that that was her best bet of having a natural birth in this hospital. So we got her on the birthing stool, and I taught her how to push. (Faye, midwife)

Later the baby’s head could be seen, and Faye was happy with the progress being made.

...At that moment the doctor walked in, and at that moment baby had receded back inside. So I’m listening to the baby’s heart beat again as the doctor was walking in. And I’m saying ‘your baby’s heart beat is beautiful, listen to that, it’s gorgeous.’ And then as the doctor walked in it’s like, ‘OK, it’s been 2 hours, we have to do an episiotomy and vacuum extraction or your baby’s going to have brain damage.’ And I just didn’t look up or say anything, I just quietly continued doing what I was doing. (Faye, midwife)

The obstetrician disregarded any knowledge Faye or the mother had about labour progress, and instead reinforced the hospital rules and timeframes. Faye told the mother to push and show the obstetrician how well she was doing. With the next push the obstetrician could also see the baby’s head and left the room saying he would return in 15 minutes. The baby was born before his return.

It was not only obstetricians who watched over and influenced events in the birth room. In the public hospital it was policy to have two midwives present for the birth of the baby. Danika was aware that her audience could influence her practice.

I’m swayed by the hospital, I know that I just like to be left alone as much as possible... I don’t, I find it kind of... I don’t call anyone into the room until bubs head’s out. I don’t want anyone there cos I don’t want them telling me... I don’t know who’s going to come in you know. If it’s a midwife that I know who practices like me, I’ll invite them in before. You know if I know that they’re going to be there. (Danika, midwife)
Navigating discord

Midwives felt pressure to practice in ways that contradicted their own beliefs, knowledge and philosophy. Rather than practice authentically, they felt obligated to tend to the needs of the institution and perform for their audience of obstetricians and other midwives in order to protect themselves. Julia talked about her struggle with the discord between how she wanted to practice, and how she was expected to practice:

It’s very, very difficult because as a midwife you are ah you know David and Goliath [laughter]. You’ve got this big thing going on around you, and personally that’s started to affect me you know in my practice. So you really can’t practice as a true midwife in that system because it’s, it’s ah, it’s big and it’s powerful. And ah when you go in there, when you put on a shirt and you put a name tag on you, you’ve become a part of that. So in a sense you can’t be a true midwife, you can’t work from a place of intuition, you can’t work from a place of connectedness because you’re part of that system that alienates that way of practising. So, yeah that’s very difficult. (Julia, midwife)

…you felt like you had to fight it a lot [own beliefs and knowledge]. You were always in turmoil with it because it was saying something, and the opposite was happening on the outside. And so in turmoil for many years and um the bullying that went on, you know in the system. From um not so much the hierarchy, but your peers, that you know, that’s been very difficult. (Julia, midwife)

Julia left the hospital system to work as a homebirth midwife which allowed her to practice in a way that aligned with her own beliefs and knowledge. Other midwives in the study also talked about their frustrations with the discord between how they would like to practice, and how they were expected to practice. Three main approaches to navigating this discord emerged from the midwives narratives: overt authenticity, cover authenticity and superficial conformity.
Overt authenticity

Only Julia (above) described being overtly authentic in her midwifery practice in a hospital setting:

And ah, you come to a place where you can’t go back [laughter], well it’s hard to go back. And then you start to feel like you… you start to feel like Joan of Arc a little bit [laughter]. You want to save every body and everything. And um, that is difficult too because you can’t save everybody, and you can’t be liked and supported by everybody either. So, how do you find… it’s a bit of a lonely road [laughter]. It’s a lonely road and you start to turn inwards… it becomes a bit of a lonely road.

Danika expressed her admiration for midwives who were able to be overtly authentic:

I really love working with people who are very strong. Um [name] have you met her? Oh she’s lovely, she’s a UK midwife. And she’s, oh she’s just so wonderfully strong and she won’t rupture membranes, you know just because someone says to, type of thing. And she’ll throw evidence back at you know the midwives who are in charge, or you know the Registrar. She’s really good with using evidence to support her practice.

(Danika, midwife)

However, Danika she felt unable to practice this way herself. None of the other midwives in the study talked about practising in an overtly authentic way within the hospital setting.

Covert authenticity

Midwives often practiced in ways that aligned with their beliefs whilst avoiding the consequences of doing so. This required manipulating the system to keep their practice hidden. For example, Danika described a number of ways in which she practiced covert authenticity including: counting the second stage of labour from pushing rather than full dilatation to avoid having to inform the obstetrician; altering the findings of a vaginal examination; and avoiding continuous monitoring for women having a vaginal birth after caesarean (VBAC):
I only count it [the second stage of labour] from pushing, yeah. And I make that... I'll actually, you know I'll document when they're fully dilated, but active second stage I'll write from when they started pushing, cos it's active, yeah, yeah. And you know I, I mean I... maybe, you know hmmm a centimetre I might've taken off here or there, or added, you know like... yeah, I've never added a centimetre actually, but I've taken a centimetre off if that makes sense. Yeah, yeah just you know at 9 and a half centimetres [laughter]. (Danika, midwife)

...if it's a past VBAC or yeah like I'll try and give people as much freedom off monitors if they're keen, and they understand the reason why we’re monitoring, and the potential risk of not being on the monitor, and if they’re happy to ‘freshen up’ for a moment then I’m happy to allow them to take longer going to the toilet. Some midwives just write ‘to toilet’ but I'll actually write ‘shower’ there as well, yeah I feel pretty OK about that. (Danika, midwife)

Again, the bathroom is used as a means of protection. A form of covert authenticity evident in the midwives' narratives was using the wishes of the mother to justify midwifery practice. This placed responsibility with the mother and protected the midwife from the institution. For Andrea this required providing information to the mother, and asserting her right to decline:

The pressure is there, always there to do things. Always there in the hospital environment... the pressure is from other people, I would say I’m pretty much more than a match for most of them... in fact all of them. And if it’s not clinically... then I’ll just get the woman, I would make sure the woman was informed and empowered enough. And I’d say the woman doesn’t want that. And I’ve done that before where they wanted to do another VE for no reason, just because they wanted to know what her cervix was like. So, I’ve explained to the woman that it's not going to change the management, and is actually clinically not indicated, and she’s got the right to refuse. And if she wants to do that I’ll support her. And they've said, ‘no I don’t want that’, so then I go back to them, to the doctor and say well she’s
actually not consenting, she’s actually refused, and so therefore I can’t allow that to happen as her midwife. And I’ve documented that in the chart that she’s declined. (Andrea, midwife)

Faye also demonstrated this approach however, she felt unable to tell the woman that she thought it was ‘normal’.

So I go in and say, ‘this is what you’re supposed to be doing now, this is the criteria, how do you feel, how is your baby, what would you like to do?’ And they say ‘yes’ or ‘no’. (Faye, midwife)

To me it was normal, not that I could say anything of this to her. But she looked at me and said, ‘no I don’t want that.’ And I went back and told them that. (Faye, midwife)

The approach of covert authenticity maintained the illusion of tending to the needs of the institution whilst protecting the midwife against the consequences of overt authenticity.

**Superficial conformity**

Midwives also shared examples of conforming to the prescribed and expected approach to practice despite maintaining alternative beliefs and knowledge. Much of the data discussed in this chapter reflects superficial conformity whereby midwives are carrying out practices that are not in keeping with their own beliefs. Isla and Helen both talked about performing routine admission cardiotocographs. Isla expressed her frustration but conformed in her actions.

Oh rules and regulations and… I mean for us personally I mean the first thing you’re doing is as soon as the woman marches through the door in labour, you’ve got to put a monitor on… It just, as I say it just drives me mad. (Isla, midwife)

Helen described how she moved from an approach of covert autonomy to superficial conformity regarding this practice. Initially she would tell women that the routine cardiotocograph was hospital policy, and support them if they declined monitoring. Then she reflected on this approach and decided an approach of superficial conformity would provide better protection from the institution:
... I don't feel good about that for practice, um especially as it’s not evidence based. Um however I think a lot of the time you can get round it, and I wouldn’t usually say that it’s hospital policy to a woman. Cos I don’t think you often need to, you just do it. And I think um I’ve probably… I’ve moved on from there. I think I felt very hurt and I was kicking the system, I didn't like the idea that this was a new policy in place. And I think it was just me being angry and hurt and whatever and if I would say about 'it’s hospital policy.’ ... And it's that kind... it’s like a rigmarole, it's things that... she is low risk, she shouldn’t need to have it done, but it is hospital policy and I have to go along with it, because otherwise at the moment my job would be threatened with it. Um so I think it’s where it’s come from. (Helen, midwife)

Edith conformed to the expectations of the hospital regarding vaginal examinations whether she felt women needed one or not.

Protocol there is to do them every 4 hours whether they need it or not, um according to the protocols, so OK, you know, you follow the protocol. (Edith)

Superficial conformity protected the midwife because it met the needs of the institution. However, midwives felt frustrated by the unnecessary interventions their practice could result in.

**RITES OF PROTECTION**

The findings presented in this chapter focus on practices that disturb the synergy between midwifery practice and women’s experience of birth. These practices address the needs of the institution and aim to protect the mother, the baby, and the midwife. The previous chapter discussed my interpretation of a ritual as a practice (words or actions) commonly or routinely carried out during birth. The clinical assessments midwives carried out during birth can be conceptualised as ‘rites of protection’. According to van Gennep (1909/1960) it can be difficult to clearly identify whether a particular ritual is a rite of passage or a rite of protection because they are often intertwined. Rites of passage aim to guide a person through a transition whilst transmitting messages about the attributes required for
their new state; and the rites of passage midwives enacted during birth were discussed in Chapter 6. The main function of rites of protection is to ensure safety during this transition. My distinction between the two types of rites in midwifery practice centres on the explicit intention behind the performance of the practice. Rites of protection are the routine practices midwives perform specifically aimed at negating the danger of birth for the mother, baby, and themselves.

**Danger and risk during birth**

Historically and globally, birth is considered a time of danger for both mother and baby. During labour women are in a liminal state physically, socially and psychologically. Douglas (1966) argues that movement from one social status to another involving a biological component is particularly dangerous. Hogan (2008) suggests that mothers giving birth straddle the line between life and death. Childbirth results in death or injury for many women (World Health Organization 2012); and the baby is also vulnerable to death and injury during birth (World Health Organization 2006b). According to Douglas (1966) the unborn baby is in a marginal state whereby their status and future is ambiguous. Because of this indefinable status, and because it is unknown whether the baby will survive the hazards of birth, the unborn baby is often treated as both vulnerable and dangerous. Kruckman (2000, p. 213) maintains that:

> … in most societies, birth and the immediate post-partum period are considered a time of vulnerability for mother and child; indeed, frequently, a time of ritual danger for the entire family or community.

Rites of protection are often associated with childbirth because of the dangerous nature of this rite of passage (van Gennep 1909/1960). Rituals reduce anxiety for the person going through the rite of passage, and for those around the person (Homans 1941; Horton 1960; Malinowski & Redfield 1948). Lahood (2007) suggests that the early ritual practices of midwifery ‘shamanism’ may have evolved in response to the danger of birth, and the altered state of consciousness associated with labour. In the previous chapters, mothers and midwives in my study described the altered state of consciousness associated with labour. In this state mothers focused within and were vulnerable to distractions and suggestions. Midwives assisted them to minimise distractions and maintain an
inward focus. It can be argued that women’s physical and psychological vulnerability during birth places them and their babies in danger, and rites of protection aim to mitigate some of this danger.

In Chapter 6, the role of the midwife was conceptualised as a ‘ritual companion’ during birth. The need for a companion, and for rites of protection appears to increase as the danger associated with the birth increase. For example, Wilson (1954) wrote about the birth rituals of the Nyakyusa tribe. The rituals performed were most elaborate during the birth of a first child, or during a complicated or abnormal birth. Symonds (2004) found that although Hmong women usually birth alone, they have another woman present if they are expecting their first baby, or if complications are more likely, for example a breech presentation or twins.

Surtees (2010) argues that earlier discourses of dangerousness have been replaced in the Western world with the concept of ‘risk’. Danger is a somewhat fatalistic notion in comparison to the more active notion of risk. Risk can be measured, monitored and minimised. Almost every midwife in my study used the word ‘risk’ at least once in relation to women’s labours, and their clinical assessments. My study focussed on uncomplicated birth rather than on births that were considered ‘risky’. However, concepts of risk underpin institutional requirements of midwifery practice even for ‘low risk’ women (MacKenzie, Bryers & van Teijlingen 2010). Therefore, midwives enacted regular, routine clinical assessments because from the perspective of the institution, such practice reduced the risks associated with birth. However, this presented a dilemma for midwives because they knew that the findings of these assessments could result in unnecessary interventions for the mother and baby that carried risk.

**Clinical assessments as rites of protection**

Every midwife in my study carried out clinical assessments and considered this to be part of their role. Midwives are expected to maintain the safety of mothers and babies (Australian Nursing and Midwifery Council 2006); and midwifery texts and clinical guidelines focus on the various clinical assessments considered to ensure safety during birth (Johnson & Taylor 2010; Queensland Health 2012). These clinical assessments are aligned with notions of ‘risk management’ within the maternity system (MacKenzie, Bryers & van Teijlingen 2010). It can be argued that these clinical assessments are aimed at checking that three factors are present during birth; maternal well-being, fetal well-being, and labour progress. In
keeping with characteristics of ritual, assessments are performed in a repetitive and patterned manner at specific time intervals. Clinical guidelines and hospital policies specify the time frames in which to perform assessments (Queensland Health 2012; World Health Organization 2006a), and the midwife’s role is to measure, assess and record these assessments (Davis-Floyd 2011; Kitzinger 2005).

Rituals reflect and transmit cultural values, and the rites of passage discussed in Chapter 6 transmitted and reflected the cultural values of the midwifery philosophy of care (International Confederation of Midwives 2010). In contrast, the rites of protection performed by midwives during birth transmitted and reflected the values of a medical paradigm. The rituals reflected a cultural emphasis on the health and safety of the baby, and the notion that surveillance and intervention can ensure safety. After World War II, the protection of future generations provided a rationale for the development and ritualised surveillance of pregnant women (Arney 1982). Antenatal care now involves the regular performance of various tests and assessments to determine the health of the baby and the mother (Grigg 2010; Sullivan, Kean & Cryer 2006). However, ritualistic surveillance is at its most intense during labour and birth. Seel (1986, p. 184) argues that the child-centred rituals performed during birth reflect cultural attitudes towards motherhood:

> It is considered appropriate for the mother to suffer discomfort, alienation and even surgery in order that the supposed needs of the baby may be satisfied. If a mother questions an obstetric procedure she is likely to be controlled with a reference to possible harm to her baby.

To be a good mother one must subordinate her needs to those of the baby. Mothers in my study underwent uncomfortable assessments during labour even when they felt such assessments were unnecessary. There was a cultural expectation that they would undergo such assessments.

Rites of protection also reinforce the compliance of the mother and the power of the professional and institution (Kitzinger 2005). Leap and Anderson (2010) refer to ‘passive rites’ that reflect a society that wants mothers who are compliant. This message is in contrast to the rites of passage that midwives performed that promoted empowerment (see Chapter 6). Whilst midwives nurtured self-trust and
inner wisdom they were also transmitting the contradictory message that clinical assessments were required to ensure safety. Mothers were usually compliant with the midwives’ need to perform assessments regardless of their own preferences.

Rites of protection for the midwife

Douglas (1966) considers that status changes involving a biological component are also dangerous for those around the person undergoing the transition. It can be argued that birth is a time of danger for the midwife caring for the mother and baby. If the mother and/or baby do not safely complete the transition there are consequences for the midwife. Her professional status may be threatened by reviews and investigations via the institution she works in; regulatory boards; and the law (McCourt 2009). In addition, when complications arise during birth there are emotional and psychological consequences for the attending midwife (Leinweber & Rowe 2010). Rites of protection performed during birth aim to promote feelings of security for mothers and midwives. In a medical paradigm, technology and clinical assessments can promote feelings of security and safety. Davis-Floyd (2003) found that in the ritual procedures involving the use of technologies enhanced feelings of confidence for women and their care providers. Rituals that reflect the perception of the birthing body as a machine that can be deconstructed into identifiable parts, then monitored and assessed can provide a sense of control over the process (Davis-Floyd & Davis 1996).

Rites of protection also reinforce the power of the institution and assert professional control (Kitzinger 2005). Midwives in my study performed rites of protection even when they were aware that the practice would not increase safety for women, and may increase the risk of complications. They also talked about alternative ways of assessing well-being that did not disrupt or undermine the mother. However, their rationale for carrying out clinical assessments was to protect themselves against the consequences of not meeting the expectations of the institutions they worked in. They talked about the dangers of not following policies and cultural norms; and they used strategies to navigate the discord that arose from attempting to meet the needs of the institution whilst remaining authentic to their beliefs.
CONCLUSION

This chapter presented findings regarding midwifery practices that were not aligned with women's experience of birth. These practices contradicted midwifery rites of passage discussed in the previous chapter. Within the explanatory framework these practices are conceptualised as rites of protection. The following chapter will discuss the findings of my study in relation to the literature.
Chapter 8

Midwifery practice as ritual companionship

INTRODUCTION

The study set out to explore midwifery practice during birth and answer the questions: what practices do midwives carry out during birth; why do midwives carry out particular practices; and how do women experience midwifery practice during birth? A narrative inquiry was undertaken and a feminist approach used throughout the research process. Birth stories shared by mothers and midwives were thematically analysed to identify themes emerging across the data. The analysis focused on the participants’ voices and their versions of events. The subjective nature of myself as the researcher was also acknowledged because as a woman, mother and midwife I explored ‘my own world’ to some extent.

The findings demonstrated that midwifery practice involves complex interactions between mothers and midwives. The theory of ‘rites of passage’ provided a useful framework in which to explain and illuminate the findings. Women’s experience of birth was conceptualised as a ‘childbirth rite of passage’ during which midwives performed ‘rites of passage’ that mirrored women’s needs. Midwives also performed ‘rites of protection’ which contradicted the rites of passage, but tended the needs of the institution. In this chapter, I discuss the answers to my research questions, and how my thesis contributes to the literature regarding midwifery practice during birth. I also present a model of midwifery practice during birth that is underpinned by the concept of midwifery practice as ‘ritual companionship’.

MIDWIFERY PRACTICE AS RITUAL COMPANIONSHIP

This thesis builds on the work of previous researchers and theorists who have used the framework of rites of passage to explore and explain the experience of
birth (Buckley 2003; Cheyney 2011; Cosminsky 1976; Davis-Floyd 2003; Hunt
1999; Jordan 1993; Kitzinger, 1979, 2005, 2006; Machin & Scamell 1997; Niska,
Snyder & Lia-Hoagberg 1998; Odent 2011; Paige and Paige 1981; Selin 2009;
Symonds 2004). My thesis extends the literature by providing evidence regarding
how specific midwifery practices interact with the childbirth rite of passage, and
by presenting a model of practice centred on the concept of ritual companionship.
The role of the midwife has been previously described as a ‘professional friend’
(Walsh 1999), a ‘safe anchor’ (Anderson 2010) and an ‘anchored companion’
(Lundgren & Dahlberg 2002). In addition, midwifery practice has been described
as consisting of ‘woman-centred care’ (International Confederation of Midwives
2010) and ‘guardianship’ (Fahy & Hastie 2008). It can be argued that
conceptualising routine midwifery practices as ‘rituals’ allows a deeper
exploration of what these descriptions look like in a practical sense. In addition,
considering a practice as a ritual facilitates an examination of the cultural
messages transmitted and reflected by that practice. This can assist in identifying
contested areas of practice that may require development and change. My thesis
is that midwives take on the role of a ‘ritual companion’ during a birth, and the
type of rituals they enact shapes the nature of the ritual companionship and
influences women’s experience of birth.

By untangling rites of protection from rites of passage I have been able to explore
the complex interactions, synergies and conflicts between different types of ritual
within midwifery practice. This enables an examination of the practical and
specific ways in which particular rituals are aligned with a ‘woman-centred’
approach. As ritual companions midwives enacted rituals during birth that
intersected with women’s needs. These rituals augmented the transformative and
empowering nature of birth. The cultural values reflected were aligned with a
holistic and humanistic approach to birth (Davis-Floyd 2001), and with the
international midwifery philosophy of care whereby the woman is central, and is
an expert regarding her own body, baby and birth (International Confederation of
Midwives 2010).

My interpretation differs from some writers regarding the values reflected in rites
of passage during birth. Literature in this area focuses on childbirth rites of
passage as a means of reflecting and conveying technocratic and medical
cultural values (Davis-Floyd 2003; Kitzinger 2006; Machin & Scamell 1997). For
example, Seel (1986) argues that there is an absence of rites during labour that
reflect the importance of the mother. However, these assertions are not supported by my findings which identified the performance of rituals that conveyed the importance of mothers in the birth process. The difference in findings may be associated with differences in context. For example, Seel (1986) and Machin and Scamell (1997) wrote about birth in the United Kingdom over a decade ago; and Davis-Floyd’s (2003) study involved women in the United States. In contrast, a recent study by Cheyney (2011) found that homebirth midwives in the United States performed rituals that transmitted and reflected the notion of the mother as expert, and honored the holistic experience of birth. Cheyney’s findings are similar to my own findings; however, the midwives in my study performed rites of passage regardless of their practice setting.

Midwives also performed rites of protection during birth that changed the nature of their ritual companionship. Birth can be a time of uncertainty and danger for both mother and baby, therefore rites of protection are commonly enacted during labour (van Gennep 1909/1960). In this thesis, rites of protection are distinguished from rites of passage by their intent to provide safety for mother, baby and midwife. Distinguishing rites of protection enabled parallel yet contradictory practices, and cultural values to be explored in relation to rites of passage. This extends previous research examining the childbirth rite of passage. Midwifery rites of protection were performed across all of the birth settings included in the study, and consisted of routine clinical assessments aimed at assessing wellbeing and labour progress. The assessments involved measurements of blood pressure, pulse and contraction pattern. However, the assessments that were most evident in the narratives were auscultation of the fetal heart rate and vaginal examinations. Both mothers and midwives talked about fetal heart rate auscultation, whereas vaginal examinations were mostly a feature of the midwives’ narratives. Bergström et al. (1992) identified vaginal examinations as a ritual repeatedly enacted during labour, and this is consistent with the midwives’ narratives. Like rites of passage, rites of protection transmitted and reflected cultural values. However, the cultural values transmitted by rites of protection contradicted the values transmitted by rites of passage. Clinical assessments could disrupt aloneness and undermine self-trust and inner wisdom. In addition, assessments could redirect the birth journey and result in unnecessary interventions. Whilst rites of protection can protect the mother and baby in some cases, they primarily tended the needs of the institution and protected the midwife.
This study provides evidence that particular rituals are effective in supporting women’s experience of birth, whilst others are not. Midwives attending births at home and in hospital enacted both types of rites, although the setting influenced how the rites were performed. Therefore, the birth setting can influence the nature of ritual companionship. Applying a model of midwifery practice based on ritual companionship facilitates a discourse around how particular rituals (practices) interact with women’s’ birth experiences. It can be argued that in order to be woman-centred, midwifery practice during birth should be focused on rituals that meet women’s needs by tending the boundaries of aloneness and nurturing self-trust and inner wisdom. Below I discuss my thesis in more detail, and locate it within the literature.

**PRACTICES THAT TEND THE BOUNDARIES OF ALONENESS**

**Managing distractions**

As the mothers in my study began to labour, external distractions from sensory input could hinder their separation from the external world. They were particularly susceptible to distractions during early labour, and used a number of strategies to block out sensory input. Midwives described how they managed distractions for mothers to assist with, and maintain separation. They created a private environment and minimised interruptions and interactions between the mother and the external world. They closed the birth room door, turned the lights low and ensured other people in the room remained quiet and calm. Cheyney (2011) and Kennedy et al. (2004) also found that midwives dimmed lights and created an environment with minimal distractions. In my study, midwives often encouraged the mother to retreat to the toilet or bathroom. This mirrored the mothers’ experiences in which retreat to the toilet or bathroom was common. Midwives identified that sending a woman to the toilet could assist with increasing space in her pelvis, and allowed her to hide away from distractions.

Some of the midwives in my study provided a rationale for managing distractions from a physiological perspective. Stimulation of the neocortex can interfere with the functioning of the limbic system, and therefore the progress of labour (Coad & Dunstall 2011; Moberg 2003; Odent 2001). The neocortex is stimulated by: bright lights; language; expectations of rationality; the feeling of being observed or monitored; thinking; and fear and anxiety. However, there also appeared to be
another purpose behind encouraging physical retreat. Midwives shared examples of sending mothers to the toilet or bathroom so they could avoid clinical assessments; and intervention and observation from other hospital staff. For example, encouraging women to have a long shower before attaching them to a cardiotocograph monitor. Fahy and Hastie (2008) argue that protecting the birth environment is an aspect of 'midwifery guardianship' whereby midwives exercise control over who enters the 'birth territory'. However, the midwives in my study did not appear to be able to control other midwives or obstetricians entering the birth space. Instead, they manipulated the environment, and the location of the mother to avoid disruption from the uncontrollable interruptions of others.

Assessing without disturbing

Whilst every midwife in my study preformed clinical assessments, they also used other methods of assessment that did not disturb the labouring woman. In particular, midwives used observation to assess women in labour based on their previous experience of women’s birthing behaviour. This approach did not require ‘doing to’ the mother. Instead, midwives watched and listened, picking up on the subtle and not so subtle cues the mother's behaviour communicated. This method of assessment was better aligned with mothers’ needs during birth because it involved minimal disturbance.

Midwives described the sounds women made, and the changes in their behaviour during labour. Using their experiential knowledge they assessed the progress of women’s labours. These findings support other research identifying how midwives use observation to assess women in labour (Baker & Kenner 1993; Lundgren & Dahlberg 2002; McKay & Roberts 1990; Winter 2002). In their study, Blaaka and Schauer Eri (2008) described how midwives used their senses to assess the birth situation as a whole, and called this ‘sensing where a woman is in her labour’. Midwives in my study noted that this approach to assessment was not always accurate because some women did not exhibit the usual sounds or behaviours. However, behavioural and visual indicators of progress have been found to be as consistent as clinical assessments (Bryne & Edmonds 1990; Burvill 2002; Cheyney et al. 2008; Duff 2005; Sheppard et al. 2010).

All of the midwives in my study also talked about experiencing intuition while caring for women in labour. A number of previous studies also found midwives experienced intuitive knowing during birth (Berg & Dahlberg 2001; Cheyney
However, the term intuition has been defined and applied in a number of different ways (Bastick 1982). Intuitive knowledge is often referred to as embodied knowledge because it is experienced as arising from within (Berg & Dahlberg 2001). In my study, midwives’ descriptions of their intuition were consistent with Benner’s (1984, p. 295) concept of an ‘intuitive grasp’ or pattern recognition intuition. Pattern recognition intuition was initially described by Benner (1984) in relation to nursing practice, and is a result of expert knowing generated by experience. Knowledge and experience are internalised to such a degree that the expert is unable to explain how she came to ‘know’. Benner (1984, p. 295) describes this phenomenon as an ‘intuitive grasp’. Midwives valued their intuitive knowing, often more than the information they gained via clinical assessments. However, they were also aware that this way of knowing was not understood or valued by others in a hospital setting. Midwives also identified that being able to develop a relationship with a mother prior to birth enhanced their intuitive knowing.

**Being with**

As labour progressed and mothers moved into the liminal phase they experienced an altered state of consciousness that produced a sense of being ‘in their own world’. They described their altered state of consciousness as being meditative, animalistic and pleasant. They also used special terms to express their sense of being in another place, which is consistent with Turner’s (1987) definition of liminality being ‘another place’. A number of studies have also identified an altered state of consciousness as a feature of the birth experience (Anderson 2010; Beck 1994; Halldórsdóttir & Karlsdóttir 1996a; Machin & Scamell 1997), and physiological explanations for this experience have been proposed (Buckley 2004; Machin & Scamell 1997; Moberg 2003; Odent 2001). Once mothers had entered this state they were less aware of, and sensitive to the external world. However, they talked about the importance of their midwife’s presence during this time. Midwives also identified presence as an important aspect of their care. Historically and globally it is common for women in labour to be attended by other women (Davis-Floyd 2011), which may seem contradictory when considered alongside the need to be alone and ‘in their own world’. However this coexisting requirement for midwifery presence and aloneness during labour has been noted in previous studies (Berg et al. 1996; Blaaka & Schauer 2008; Halldórsdóttir & Karlsdóttir 1996a; Lundgren & Berg 2007).
essence of presence in my study was being ‘with woman’ without distracting or disturbing her. This supports the findings of other studies identifying midwifery presence as ‘being with’ rather than ‘doing to’ (Anderson 2010; Beech 2005; Halldórsdóttir & Karlsdóttir’s 1996a; Kennedy & Shannon 2004; Lundgren & Dahlberg 2002; MacLellan 2011; Pembroke & Pembroke 2008; Walsh 2007). In addition, for the mothers, and midwives in my study, presence was more about availability than a close physical presence. Midwives did not necessarily need to be in the same room as the mother to be present with her.

Assisting reintegration

Midwives assisted women’s progressive reintegration with the external world. First mother and baby integrated with each other, and midwives supported this by encouraging skin-to-skin contact and early breastfeeding. Next mother and baby reintegrated with the woman’s partner. Midwives in my study talked about assisting this by providing space and privacy, often by leaving the room. A study by Halldórsdóttir and Karlsdóttir (1996a, p. 56) referred to this time following birth as the ‘world of three’. Eventually the mother moved to the postnatal ward where family and friends could visit. It can be argued that incorporation is managed by visiting times and in some cases hospital rules regarding the number of visitors.

My research centred on the experience of birth, therefore I did not specifically collect data about the postnatal period. However, Seel (1986) suggests that the lack of incorporation rituals in the modern Western world is associated with problems adjusting to parenting.

PRACTICES THAT NURTURE SELF-TRUST AND INNER WISDOM

Reinforcing self-trust

For mothers, the cultivation of self-trust began in pregnancy, and midwives then reinforced self-trust during labour. Midwives did this through ritual nurturing of the mother’s expertise and ability during labour. They repeatedly told women that they ‘could do it’, and to ‘follow their body’. These findings support Cheyney’s (2011) study of homebirth midwives in the United States. In my study the ritual reinforcing of self-trust occurred across all birth settings. Midwives provided reassurance and encouragement rather than guidance or instructions. Previous studies have identified that mothers seek guidance about how to birth from their
midwives (Berg et al. 1996; Hall & Holloway 1998). However, this did not emerge as a finding in my study, and generally mothers did not express a need for guidance during labour. There were some instances in which guidance was mentioned, but guidance generally appeared to be something the midwives gave only in response to a need, not routinely or ritualistically. In contrast, the routine use of encouragement and reassurance was a feature of every narrative, and these findings are consistent with previous studies (Anderson 2010; Berg et al. 1996; Halldórsdóttir & Karlsdóttir’s 1996a; Kennedy & Shannon 2004; Lundgren and Berg 2007).

Half of the mothers in my study described a point in their labour where they experienced self-doubt, and felt overwhelmed and unable to cope. Midwives also identified that this was a common feature of the labour experience. Turner (1987) considered that the liminal phase involves a sense of ‘undoing’ and ‘dissolution’, and this aligns with women’s experiences. Midwifery literature refers to a ‘transitional’ stage during the labour process in which women become distressed and overwhelmed emotionally (Fraser & Cooper 2008; Thorpe & Anderson 2010). Midwives in my study met mother’s needs during this time by providing reassurance and encouragement. They reinforced mother’s self-trust by conveying their belief in her ability to birth. The essential message midwives transmitted to women was ‘you can do this yourself’.

**Reflecting inner wisdom**

It was not until the expulsive phase of labour that mothers experienced their body taking over control. At this point in labour, midwives focussed the mother’s senses onto her body, encouraging her to listen, watch, and feel her body birthing. Again, their words reflected their belief in the woman’s ability to birth. These findings are not consistent with studies exploring midwifery practice during birth. Midwives commonly direct women’s pushing behaviour (Peterson & Besuner 1997; Sampselle et al. 2005; Thomson 1993; Walsh 2000), and these instructions are often at variance with women’s instinctive pushing behaviours (Aderhold & Roberts 1991; Bergström et al. 1997; McKay, Barrows & Roberts 1990; Rossi & Lindell 1986; Thomson 1995). Only one midwife in my study routinely directed pushing, and none of the mothers reported having their pushing directed. An early study by McKay, Barrows and Roberts (1990) found that a belief in the ability of women to birth without instruction was only evident within a homebirth
setting. However, two midwives in my study commented on how they had seen a change in hospital practice towards undirected pushing.

Many of the midwives and mothers in my study talked about the use of mirrors during birth. Mirrors were used to reflect the body working, and provide visual evidence of progress for mothers. Davis-Floyd (2003) also found the mothers in her study were encouraged to observe themselves birthing via mirrors held by doctors or nurses. She argues that birth becomes reflexive when a mother becomes aware not only of the ‘Other, the baby, but of herself giving birth to the Other’ (p. 133). In my study mothers were actively birthing on their own terms. The offering of the mirror by midwives was an attempt to allow them to witness their body working, and to reinforce their active participation in the process.

**Contributing to empowerment**

Although midwives in my study were aware of the empowering nature of birth, they did not explicitly talk about their role in this. Instead, it can be argued that midwifery practice that nurtured self-trust and inner wisdom supported an empowering birth experience. This may reflect the midwife’s role as a ritual ‘companion’ rather than Turner’s (1987) notion of ‘instructor’. Midwives did not take credit for the empowerment that women derived from their birth experience. Whilst the midwife’s role was clear in the physical reintegration described above, it was not explicit in the incorporation of the birth experience into the women’s sense of self. However, Cheyney (2011) suggests that midwives perform rituals in the immediate postpartum period that encourage incorporation, including delayed cord clamping, maintenance of mother-baby contact, and celebration of the placenta. The midwives in Cheyney’s (2011) study believed that reinforcing maternal pride and power at this time were essential components of bonding, and empowered mothering. The midwives in my study also talked about delayed cord clamping and maintenance of skin-to-skin contact. However, they did not talk about these practices as being empowering. Instead, they considered the practices to be evidence-based and the cultural norm in their workplace. Perhaps a model of ritual companionship would assist midwives to understand the empowering nature of such practices.
PRACTICES THAT TEND THE NEEDS OF THE INSTITUTION

The ritual clinical assessments performed during birth involved midwifery practice that was contradictory to the woman-centred nature of ritual companionship discussed above. Whilst occurring alongside rites of passage, rites of protection were not aligned with women’s experience of birth. Primarily, midwives performed ritual clinical assessments to meet the needs of the institution. The institution consisted of, the medical and obstetric paradigm; the hospital culture; workplace guidelines and policies; midwifery regulatory bodies; and established customs and expected practices. By tending to the needs of the institution they were able to protect themselves.

A requirement of the institution is risk minimisation, and rites of protection involving clinical assessments reflect and transmit a culture in which ‘risk’ is a dominant discourse. Midwives talked about ‘risk’ in relation to caring for women during birth, yet notions of risk were conflicted. Midwives performed clinical assessments as part of institutional requirements for risk minimisation. However, the findings of these assessments could result in unnecessary intervention which created risk for the mother and baby. It can be argued that the risks involved in failing to perform a clinical assessment were for the midwife, and were related to not fulfilling her expected role within the institution. A study by Surtees (2010) of midwives in New Zealand identified that midwives practised ‘defensively’ in order to protect themselves against potential future medico-legal action. My findings support this, however the midwives in my study were more focussed on the immediate workplace implications of not following institutional policies and cultural norms rather than future legal action. They also talked about the requirement to document their clinical assessments in order to provide evidence of their practice. Davis-Floyd (2011) argues that the institution has a need for information, and midwives must act as ‘information collectors’; and this concept was reflected in the narratives of midwives in my study.

Midwives expressed a sense of being observed and monitored, and they adjusted their practice to protect themselves against the consequences of not meeting the needs of the institution. Their audience consisted of colleagues who enforced policies, guidelines, and professional governance. Midwives in my study gave examples of working under both direct and indirect surveillance. For example, documentation was a form of indirect surveillance, as midwives needed to provide written evidence that they were performing as required. They were
also indirectly observed by staff outside of the birth room who they needed to keep informed about events inside the birth room. In particular, they were required to inform obstetricians if clinical assessments placed a woman outside specified timeframes or boundaries. Midwives admitted to altering their practice according to which midwives and obstetricians were in the clinical area. Midwives also gave examples of direct supervision whereby obstetricians entered the birth room and observed their practice, often criticising what was happening. In the hospital setting it was policy to have two midwives in the room during birth. The midwife who was called in to assist could influence the practice of the midwife already in the room. The nature of midwives’ ritual companionship was influenced and shaped by the requirements of the institution. The result of the rituals enacted by midwives to meet the needs of the institution influenced women’s experience of birth and created emotional conflict for midwives. These findings extend the literature and dialogue around the experience of contested areas of practice.

Disrupting aloneness and undermining self-trust and inner wisdom

Midwives were aware that their assessments could be distracting for women. In addition, clinical assessments could undermine self-trust and inner wisdom by reinforcing the value of external expertise. Midwives did not explicitly link clinical assessments with undermining mother’s inner wisdom. However, mothers talked about their midwives performing clinical assessments in spite of their own knowledge. It could be argued that ritualistic assessment of wellbeing and progress suggests a mistrust of the mother’s ability to birth. This contradicts the message conveyed via rituals in which midwives expressed their belief in mothers’ ability to birth. These findings support previous literature that routine assessment and monitoring can undermine a women’s own knowledge about her body and her baby (Anderson 2010; Parratt 2008).

Leap and Anderson (2010) suggest that the ritual use of clinical assessments reflects a society that wants mothers to be compliant and biddable, rather than strong. This message is in direct contrast with rituals that reinforce the mother as expert, and reinforce the empowering nature of birth. It can be argued that my findings support Anderson’s notion as the mothers in my study allowed midwives to carry out clinical assessments despite finding them uncomfortable and unnecessary. They also complied with midwives’ need to assess and monitor
them, regardless of their own knowledge about their labour progress and wellbeing. It can be argued that the complex and contested practice of ritual companionship is evident in this finding.

Redirecting the journey

Midwives talked about how their clinical assessments could result in a redirection of the birth journey towards unnecessary intervention. Fetal heart rate auscultation, and vaginal examinations, were the two assessments that appeared to be most likely to result in intervention. Intermittent auscultation of the fetal heart is a clinical assessment performed routinely by midwives during birth. Specific timings of the assessment are outlined in clinical guidelines (Queensland Health 2012; RANZCOG 2006). However, these frequent timeframes are not aligned with empirical evidence on less frequent regimens of auscultation (Downe & McCourt 2008). Towards the end of birth the recommended timing of auscultation increases to ‘after each contraction during active pushing’ (RANZCOG 2006, p. 7). Decelerations of the fetal heart rate are normal towards the end of birth as the baby moves through the vagina and is subjected to head compression (Howie 2010c). Guidelines classify such decelerations as ‘non-reassuring’ requiring referral to an obstetrician (RANZCOG 2006). Midwives in my study talked about how identifying decelerations via auscultation often resulted in interventions, because once they had notified the obstetrician, action would be taken to deliver the baby using instruments. Midwives expressed distress and a sense of powerlessness to prevent such action.

Vaginal examinations were performed by midwives to assess the progress of labour according to institutional guidelines defining acceptable rates of cervical dilatation. These notions of labour progress reflected a biomedical concept of ‘stages of labour’. In addition, midwives talked about the inaccuracy of vaginal examinations in determining future progress, which is consistent with the findings of other studies (Winter & Duff 2009). However, vaginal examinations provided information which could lead to interventions including: augmentation, directions regarding pushing, and instrumental delivery. These assessments could also result in disillusionment and concern for a woman who had not attained a cervical dilatation deemed adequate; or if the findings did not match the woman’s

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1 Royal Australian and New Zealand College of Obstetricians and Gynaecologists
perception of her own labour progress. This supports previous studies identifying that discrepancies between women’s perceptions of labour progress and midwives’ assessment of labour progress can result in anxiety and distress (Barnett et al. 2008; Baxter 2007; Eri et al. 2010; Scotland et al. 2011). Whilst midwives expressed their frustrations about having to perform vaginal examinations, they generally did not challenge the practice within their working environment. Indeed, one midwife referred to vaginal examinations as a ‘necessary evil’.

**Navigating discord**

Midwives felt pressure to perform clinical assessments that contradicted their own beliefs and knowledge about birth. They expressed frustration at not being able to practice authentically, and at the policies they were required to follow to meet the needs of the institution. Ritual companion was conflicted by the requirements of the institution. My findings relating to midwives’ experiences of a discord between practice and beliefs are consistent with Hunter’s (2004) study which identified two conflicting ideologies within midwifery work settings, ‘with-woman’ and ‘with institution’. Hunter found that it was often impossible for midwives to maintain a ‘with-woman’ approach in a hospital setting and this dissonance of ideologies resulted in negative emotions. She identified these conflicting ideologies as a source of ‘emotion work’ in midwifery. In her study, midwives and student midwives described having to work on their emotions to maintain an appropriate ‘professional performance’. They experienced anger, anxiety and frustration, which resulted from the dissonance of the two conflicting ideologies, ‘with woman’ and ‘with institution’. Other studies have also identified similar experiences of frustration arising from conflicting ideologies (Kirkham 1999; O’Connell & Downe 2009). Blaaka and Schauer Eri (2008) described the experience of midwives mediating between two belief systems as ‘being in a room of struggle’. In this room there was a battle between a biomedical knowledge tradition, and a sensual knowledge tradition. My findings are consistent with these studies. It can be argued that the midwives in my study struggled with how the institution influenced the nature of their ritual companionship.

Midwives in my study who practiced in a homebirth setting identified differences in their ability to practice authentically and focus on the woman rather than the
institution. They were not under direct supervision, and were not required to be ‘doing’ and documenting ‘doing’ to meet the needs of the institution. This allowed them to focus on the woman’s behaviours rather than clinical assessments. They were also able to develop a relationship with the woman during pregnancy which further facilitated their use of observation and intuition during labour. Hunter (2004) also found that midwives working in community environments were more able to demonstrate a ‘with woman’ approach to their practice which was emotionally rewarding. It appears that the ability of a midwife to express woman-centred ritual companionship is enhanced by the context of maternity care.

It can be argued that whilst midwives continue to be employed by technocratic institutions, rather than directly by women, they will be unable to truly be with woman and provide care based on feminist principles. An increasing number of women in Australia are hiring private doulas (Stevens et al. 2011). Doulas provide physical and emotional support to women before, during and after birth. The doula’s role in labour is to be with the woman throughout the experience and provide encouragement and support. Doulas are not medical professionals and do not perform any assessments of wellbeing or progress during labour. A study by Stevens et al. (2011) identified that doulas are employed by women to ‘fill the gap’ in the maternity system. By hiring a doula they get continuity of care by someone they know, who is directly employed by them rather than by the institution, and who can focus primarily on their needs. During labour doulas are unable to perform clinical assessments and instead focus entirely on the needs of the woman. Therefore, it can be argued that they perform rites of passage without also enacting rites of protection. Dahlen and Jackson (2011) and Stevens et al. (2011) maintain that the demand for doulas is a consequence of midwives being unable to provide ‘with woman’ care within a fragmented, medically dominated maternity system. It could be argued that midwives are so constrained by the institutions they are employed by that they have become primarily the performers of rites of protection whilst doulas have become the performers of rites of passage.

Midwives in my study navigated the discord created by conflicting ideologies in a number of ways. Three main strategies were identified from the data: superficial conformity, covert authenticity and overt authenticity.

Superficial conformity involved conforming to the prescribed and expected approach to practice, whilst maintaining alternative beliefs and knowledge. Every
narrative in my study included examples of superficial conformity. Midwives carried out vaginal examinations, placed women on cardiotocograph monitors, informed obstetricians of particular fetal heart rate patterns, and participated in the unnecessary interventions resulting from their assessments. They talked about ‘having to’ carry out these assessments, yet expressed frustration at the resulting interventions. A number of other studies have identified that midwives carry out practices that are not aligned with their own beliefs (Lewis & Rowe 2004; Mercer, Nelson & Skovgaard 2000; Surtees 2010). In a metasynthesis of midwives’ experience of practice in hospital, O’Connell & Downe (2009) found that one of the broad areas of activity involved ‘enforcing compliance to technocratic norms in order to ‘get through the work’’. Surtees (2010) identified the theme ‘playing it safe’ to explain how midwives conformed to cultural norms in order to protect themselves from iatrogenic and professional risk. The midwives in my study superficially conformed to the cultural norms of the institution. By doing so they were protected from criticism and the implications of not meeting the requirements of their role within the institution. However, by superficially conforming they became frustrated because they were unable to practice authentically.

Covert authenticity was also common in the midwives’ narratives and involved practicing in a way that was aligned with personal beliefs and knowledge, but not doing so openly. Midwives used a number of strategies to practice in covertly authentic ways. They manipulated the findings of clinical assessments, for example documenting that a woman’s cervix was ‘9cm dilated’ rather than ‘fully dilated’ to ‘buy’ her more time; they sent women to the toilet, or to the bathroom to avoid attaching them to a cardiotocograph monitor. These findings are consistent with other studies identifying how midwives manipulate situations to avoid carrying out practices they do not believe in (Bluff & Holloway 2008; O’Connell & Downe 2009; Parsons & Griffiths 2007; Peterson & Busuner 1997). Kirkham (1999) described this type of midwifery behaviour as ‘doing good by stealth’; and Parsons and Griffiths (2007) referred to it as ‘rule bending’.

Midwives in my study described using the wishes of the mother to justify practicing authentically. This form of covert authenticity placed the responsibility with the mother and protected the midwife from the institution. An example of this approach involved explaining to a woman that it was hospital policy to do a vaginal examination. However, also explaining that there was no need to do so,
and that she could decline if she wished. If the woman then chose to decline, the midwife relayed her choice to the obstetrician and documented her refusal. Covert authenticity protected the midwife and the mother, and allowed the midwife to practice in a more authentic way.

Overt authenticity involved a midwife openly practicing according to her own beliefs and knowledge. Only one midwife in my study, described using this approach in a hospital setting, and described it as ‘a lonely road’. Bluff and Holloway (2008) found that midwives who did not conform to the cultural norms of their workplace were ridiculed and bullied. This is consistent with the experience of the midwife in my study who was overtly authentic. Whilst other midwives expressed their admiration of overt authenticity, they were not willing to take the risk of practicing in this way. Overt authenticity allowed the midwife to practice in a way that was aligned with her beliefs, and protected mothers from unnecessary intervention. In contrast, it can be argued that the approaches of covert authenticity and superficial conformity sustain the cultural norms of the institution rather than challenging them (Kirkham 1999; O’Connell & Downe 2009). My findings suggest that the way in which a midwife navigates discord influences the nature of her ritual companionship. This has implications for women’s experience of birth, and for the maintenance of institutional cultural norms.

CONCLUSION

In this discussion of the findings I have presented a model of midwifery practice as ritual companionship. The particular rituals that influence the nature of ritual companionship, and the experience of birth for women were discussed as they reflect and extend the current literature. In addition, how the institution influences midwives’ practice as ritual companion, and the impact of this on women, babies, and midwives was discussed. The following chapter concludes this thesis and provides recommendations for practice arising from the key findings and based on a midwifery practice as ritual companionship.
Chapter 9

Conclusion

I think women pick up when you are speaking from a place that's true rather than a place that's being... that you've kinda been taught to say, you know. You're speaking from the heart, that's basically it yeah, rather than covering... you know ticking all the boxes and having... and getting all the paperwork done [laughter]. (Julia, midwife)

CONCLUSION OF FINDINGS

This thesis told the story of a research study that explored midwifery practice during birth. It presented and discussed a narrative of midwifery practice shaped by the birth stories of participants, my own story, and the broader context of midwifery care. The explanatory framework of rites of passage was applied to the findings to further illuminate the complex interactions between midwives and mothers during birth. The study posed three questions: what practices do midwives carry out during birth; why do midwives carry out particular practices; and how do women experience midwifery practice during birth? The findings identified that midwives performed two types of practices which intersected with women’s experience of birth in differing and contested ways. They carried out practices that met the needs of women, and practices that met the contradictory needs of the institution. My thesis is that midwifery practice during birth can be conceptualised as ‘ritual companionship’. Considering routine practices as rituals encourages an exploration of the cultural messages reflected and transmitted by particular practices. This exploration may contribute to a discourse about midwifery practice during birth, women’s experience of birth, and the influence of the institution on the nature of ritual companionship.
**DIALOGUE FOR FUTURE DIRECTIONS IN MIDWIFERY PRACTICE**

Whilst the findings of this research are specific to the study, they may also be transferable, and can contribute to the dialogue informing midwifery practice. The recommendations presented in this chapter centre on a model of midwifery practice as ritual companionship. The nature of this ritual companionship can reflect a woman-centred approach by being aligned with women’s experience of birth. Therefore, rituals that tend the boundaries of aloneness, and rituals that nurture self-trust and inner wisdom could become a focus of midwifery practice, education and research. It can be argued that these rituals are, to some degree ‘hidden’ within clinical workplaces and midwifery education and research. Instead, there is a focus on rituals, such as routine clinical assessments that meet the needs of the institution. This focus is reflected in documentation, clinical guidelines, curricula, and textbooks. Conceptualising the role of the midwife as a ritual companion may assist in explicitly establishing the value of practices that transmit and reflect woman-centred cultural messages.

In view of the lack of evidence supporting the routine use of many clinical assessments during labour; the ritual performance of such assessments could be reconsidered. It can be argued that midwifery needs to develop its own body of knowledge and ways of knowing about wellbeing and progress during labour. I am not suggesting that clinical assessments are abandoned altogether. Instead, the routine, ritualistic use of such assessments, and the notion of them as the only valid method of gaining information about progress and well being needs to be challenged. It can be argued that the performance of such rituals influences the nature of ritual companionship in way that is not aligned with women’s experience of birth. Examining the cultural messages being transmitted by routine practices may encourage a dialogue around how practices can be performed differently.

During the process of this study it became apparent that the concept of ‘stages of labour’ is unhelpful for a number of reasons. The concept is embedded in a biomedical paradigm, and there is a lack of evidence supporting it. The notion of stages of labour does not reflect women’s experiences of birth (Dixon, Skinner & Foureur 2012), therefore is not consistent with woman-centred ritual companionship. Attempts to measure stages using clinical assessments are inaccurate in determining future labour progress (Winter & Duff 2009); and transmit cultural messages that reinforce the expertise of the institution rather than the woman-centred approach of midwifery.
than of the woman. Enforcing parameters of ‘normal’ progression through stages can result in unnecessary interventions. However, practice guidelines and textbooks continue to define labour as consisting of stages that can be measured in a meaningful way (Johnson & Taylor 2010; Queensland Health 2012). Midwives educate women about the stages of labour in antenatal classes; they assess women’s progression through the stages; and they document the hours and minutes that women apparently spend in each stage of labour. By continuing to support the notion of measurable stages of labour, midwives sustain this paradigm.

The midwives in my study struggled to practice in an authentic way within the institutions they worked in. These findings are consistent with other research identifying the difficulties and frustrations midwives encounter with the discord between the way they want to practice, and the cultural norms of their workplaces (Blaaka & Schauer Eri 2008; Hunter 2004; Kirkham 1999; O’Connell & Downe 2009). The institution influenced the nature of midwives’ ritual companionship, which impacted on their emotional wellbeing. Whilst I have argued that the culture of the workplace needs to be challenged and changed; in the meantime midwives continue to navigate their way through this discord on a daily basis. It may be helpful to make this discord more explicit, and encourage an open discourse about these issues, in order to identify ways to support midwives.

This chapter will now outline how a model of ritual companionship could be expressed in the context of midwifery care, midwifery practice, midwifery education and further research.

SUGGESTIONS ARISING FROM THE FINDINGS

Suggestions for the context of midwifery care

The context of care influences midwifery practice and women’s experience of birth and midwifery practice. Therefore, attention must be focussed on developing maternity services that support woman-centred midwifery practice.

In 2011 the Commonwealth of Australia released the ‘National Maternity Services Plan’ outlining the future direction of maternity services in Australia (Commonwealth of Australia 2011). Many of the proposed plans for change support the recommendations arising from my study regarding improvements to
maternity services and midwifery care in general. The national plan identifies a 'wellness paradigm' as the underpinning philosophy of maternity services. In addition, I recommend a holistic approach should replace the current technocratic approach. This would better reflect the holistic nature of pregnancy and birth, and encourage critical reflection regarding the role of technology and medicine in a normal physiological process. The maternity plan also identifies that services will be embedded in the community rather than centralised in tertiary hospitals; and will include increased access to birth centres and homebirth. Midwives in my study identified the pressure within hospital settings to tend to the needs of the institution, often to the detriment of the birthing woman. There is evidence to support the notion that midwifery led birth centres and homebirth support a woman-centred approach to midwifery (Cheyne 2008; Dahlen & Jackson 2011; Foureur 2010; Walsh 2006; 2007). Moving normal birth out of hospitals may help to refocus care back onto the woman and assist with the development of a more woman-centred work culture.

It can be argued that the philosophy of midwifery is feminist in nature. The International Confederation of Midwives (2010) maintain the importance of empowerment for women within midwifery philosophy and models of care. Walsh (2004) provides a summary of key values underpinning feminism that could also underpin midwifery care. These values include: the primacy of women's experience; listening to and valuing women's voices and their version of events; establishing relationships based on equality and reciprocity; unmasking dehumanising and oppressive practices against women; and action for empowerment and emancipation.

The National Maternity Services Plan maintains that continuity of care should be a fundamental aspect of all maternity models of care (Commonwealth of Australia 2011). Participants in my study also identified continuity of midwifery care as being beneficial for the mother and midwife. Knowing the mother before labour was considered to be the ideal, even for those midwives not working in this model of care. For mothers, establishing a connection with the midwife in pregnancy assisted with building self-trust, and with separation. For midwives having a connection with the mother before labour enhanced their use of intuitive knowledge during labour, and this finding was consistent with other studies (Cheyney 2008; Davis-Floyd & Davis 1996). Midwives also felt more able to be ‘with the woman’ rather than ‘with institution’ when they had formed a relationship.
with the mother. Care by a known midwife throughout the childbearing experience is considered by many to be the foundations of good midwifery care (Brown & Lumley 1998; Kennedy et al. 2004; Leap 2010; McCourt et al. 2006; Winter 2002).

**Suggestions for midwifery practice**

Foregrounding woman-centred rituals could involve both macro and micro changes in midwifery practice. The need to minimise external distractions and assist women to focus inwardly can be considered when designing birth spaces. For example, using architecture and furnishings that facilitate privacy and comfort (Hastie 2011); and the provision of ensuite toilets and bathrooms for women to retreat into. The relocation of birth from hospitals into smaller birth centres may facilitate the development of birth spaces that better meet women’s needs for seclusion and retreat (Hodnett, Downe & Walsh 2012; Walsh 2004).

On a micro level, midwifery practice during birth can be focused on managing external distractions - closing the birth room door, turning lights low, encouraging retreat to the bathroom/toilet; ensuring that other people in the room remain quiet and calm. Midwives already do this, but it is not explicit or overtly valued in the clinical setting. Perhaps ‘environmental assessment’ could be included in practice guidelines and recorded in clinical documentation to make this role more explicit to midwives and reflect its value.

Midwifery presence is important for women and centres on a ‘being with’ rather than a ‘doing to’ approach. Midwives can be encouraged and supported to find ways of just ‘being’, and if they must ‘do’ something, to focus on activities that create a sense of presence without disturbance, for example knitting (Kennedy & Shannon 2004). This may be difficult within a hospital culture of efficiency whereby staff are expected to be ‘doing’. Again, a relocation of birth from hospital into birth centres may assist with a cultural shift.

Rethinking the concept of ‘stages of labour’ may assist in the development of an understanding of labour that is aligned with what Downe and McCourt (2008) refer to as ‘unique normality’. It can be argued that the phases of separation, liminality and incorporation offer a more holistic representation of the birth journey that is better aligned with women’s experience of labour. These phases are not based upon what the cervix is doing, but rather on the specific physical and
emotional needs of the mother. A move away from 'stages' will involve a paradigm shift including a change in the language midwives use to describe labour.

Midwives use observation to gain information about wellbeing without disturbing the labouring woman. Behavioural and visual indicators of progress have been found to be as consistent as clinical assessments (Bryne & Edmonds 1990; Burvill 2002; Cheyne et al. 2008; Duff 2005; Sheppard et al. 2010). Developing clinical documentation that enables the recording of this information may offer an alternative method of assessment which is aligned with women’s needs. This would also make explicit the value of the embodied knowledge and intuition midwives are already using to gain information about women’s labour.

Further implementation of models of care that are centred on building mother-midwife relationships could facilitate the foregrounding of rites of passage in a number of ways. My study found that for mothers, establishing a connection with the midwife in pregnancy assisted with building self-trust and with separation. For midwives, having a connection with the mother before labour enhanced their use of intuitive knowledge during labour. Midwives also felt more able to be ‘with the woman’ rather than ‘with institution’ when they had formed a relationship with the mother. It can be argued that if a midwife has a relationship with a women prior to labour, she may be more likely to prioritise the woman over the institution.

The impact of the discord between how midwives want to practice, and the expectations of their work settings is clear. It can be argued that acknowledging this discord as an integral aspect of midwifery would facilitate discourse about this issues, resulting in identifying possible coping strategies. Midwives could work together to identify ways of supporting each other within the workplace setting. They could focus on the development of nurturing work environments, and implement mechanisms for midwives to de-brief and gain support from one another. For example, group meetings or a ‘buddy’ system. Open discussion amongst midwives around navigating discord may enable them to identify ways of facilitating changes in workplace culture. Midwives may find it easier to practice authentically in settings where the culture is aligned with their beliefs, for example, homebirth or midwifery-led birth centres. Therefore, further expansion of these options for both women and midwives is recommended.
Suggestions for midwifery education

Standards and criteria for the accreditation of courses leading to registration as a midwife state the importance of a woman-centred, holistic focus in curricula (Australian Nursing and Midwifery Council 2009). Midwifery students could be supported to learn about the process of birth in a holistic way, rather than focussing on physiological definitions relating to cervical dilatation. The use of women’s birth stories as a central learning resource may assist with encouraging a focus on women’s experience of birth. In addition, midwifery students could be supported to develop critical thinking regarding a biomedical approach to birth and it’s implications for women.

Encouraging midwifery students to examine the messages conveyed by practices may also assist with teaching and assessing a woman-centred approach. Conversation, reflection and debate around the rituals enacted by midwives can be built into curricula. This would assist midwifery students to develop critical reflection regarding the role of technology and medicine in a normal physiological process.

The use of simulation in midwifery education is becoming increasingly popular (Fox-Young et al. 2012). However, it can be argued that simulations tend to focus on the management of clinical emergencies or clinical assessment skills. Simulations about ‘being with’, creating an appropriate birthing environment, performing clinical assessments with minimal disturbance; may assist students to develop these skills and convey the value of these practices. It can be argued that continued professional education for midwives is also centred on managing clinical emergencies. Mandatory clinical updates usually involve obstetric emergencies, cardiotocograph interpretation and neonatal resuscitation. Again, reflecting a valuing of these skills over practices that meet women’s needs during a normal, physiological birth. Perhaps mandatory updates on midwifery practices that are aligned with women’s needs during birth would assist in a cultural shift.

Midwifery students struggle with the discord between the midwifery philosophy they learn at university, and the expectations of their clinical placements (Fenwick, et al. 2012; Hobbs 2011; Van kelst et al. 2012). Changes in the context of midwifery such as those recommended above may alleviate this discord. However, it can be argued that the current challenges need to be addressed within midwifery curricula. The discord that midwifery students encounter can be
made explicit, and they can be encouraged to reflect on their experiences within a supportive environment. Strategies for building resilience and practical approaches for dealing with conflict could be taught. Simulations may assist students to practice and reflect on their response to situations involving discord, for example, how to deal with being asked to conduct a practice that is not supported by evidence and may result in harm.

**Suggestions for further research**

Further research is required into contexts of midwifery care, birth environments, and practices that assist women to focus inward during labour; and how such practices can be taught to midwifery students.

The findings of my study supported previous research identifying the empowering nature of the birth experience (Budin 2001; Cheyney 2011; Kennedy et al. 2004; Lundgren 2005). This aspect of birth requires further research, including an examination of how midwifery practice influences women’s sense of empowerment.

Further research is required to better understand the experience of birth for women, and develop a discourse around birth that reflects their experience. In addition, research exploring how the concept of stages of labour influences midwifery practice and education would be useful.

Rituals that are not aligned with women’s experience of birth can be critically examined to determine whether they can be disregarded, or enacted in a more woman-centred manner.

The influence of the institution on ritual companionship, women, babies, and midwives could be examined further.

Further research into midwives’ experience of practicing within a culture that is not aligned with their own beliefs and philosophy is required. In addition, research exploring how best to support midwives, and student midwives experiencing discord is needed.
NARRATIVE AND MIDWIFERY

This study was a narrative inquiry, and asserted that narrative and story telling is fundamental to midwifery, and to women's ways of knowing. Therefore, it can be argued that narrative approaches to midwifery practice, education and research offer a valuable way of building knowledge in which women are central.

The mothers in my study found other women’s birth stories assisted them to build self-trust and prepare for birth. These findings are consistent with other studies (Callister 2004; Dahlen, Barclay & Homer’s 2008; Ketler 2000). Therefore, a narrative pedagogical approach to antenatal education may better meet women’s needs. A narrative approach to antenatal education sessions would encourage women to exchange stories and learn from one another whilst also gaining emotional and social support (Carolan 2005; Farley & Widman 2001; Savage 2001). Building childbirth education around woman-to-woman story sharing would also reinforce women as the experts in birth, and this would further facilitate the development of self-trust.

In midwifery education, embracing narrative is a key approach to learning. In the development of a women-centred approach to midwifery, women’s experiences and stories can to be central to knowledge building (Brook & Barnes 2001; Reed 2011). Midwifery students can learn from women’s experiences and their perceptions of birth and midwifery care. In addition, students can be offered the opportunity to share their own stories, and learn from each other. A narrative pedagogy is also aligned with a feminist philosophy and approach to learning (Brook & Barnes 2001; Davies 2004).

Narrative methodologies offer midwifery researchers an approach which is aligned with the culture of their participants – women and midwives. It enables the exploration of midwifery and birth from the perspective of those involved, and places value on the voices of participants. In addition, narrative inquiry is aligned with a feminist approach to research.
CONCLUDING COMMENTS

The findings of this study make both theoretical and practical contributions to the understanding of midwifery practice during birth. The findings represent a narrative of midwifery practice co-constructed by myself, the participants, and our ‘storytelling relation’ (Frank 2000). The thesis offers a model of midwifery practice as ritual companionship in which to explore practice and its interaction with women’s experience of birth. Recommendations for the application of the findings to the context of midwifery care, practice, education and research have been presented in this chapter. This study is now complete and has changed the way I understand midwifery, birth and research. It represents a fundamental step in my continuing journey of inquiry and practice. I offer my contribution to the ongoing narrative of midwifery practice during birth.


Anderson, T 2010, 'Feeling safe enough to let go: the relationship between a woman and her midwife during the second stage of labour', in M Kirkham (ed), The midwife-mother relationship, 2nd edn, Palgrave Macmillian, Basingstoke.


Australian Government, 2007, National statement on ethical conduct in human research, National Health and Medical Research Council, Australian Research Council, Canberra.

Australian Institute of Health and Welfare 2012, Nursing and midwifery workforce 2011, National health workforce series, no. 2, Cat. no. HWL 48, Canberra: AIHW.


Australian Nursing and Midwifery Council 2009, Standards and criteria for the accreditation of nursing and midwifery courses leading to registration, enrolment, endorsement and authorisation in Australia – with evidence guide, ANMC.


Berg, M & Dahlberg, K 2001, ‘Swedish midwives’ care of women who are at high obstetric risk or who have obstetric complications’, Midwifery, vol. 17, pp. 259-266.


Bergström, L 1997, "'I gotta push. Please let me push': social interactions during the change from the first to second stage of labour', Birth, vol. 24, no. 3, pp. 173-180.


Cluett, ER & Bluff, R 2006, 'From practice to research', in ER Cluett & R Bluff (eds), Principles and practice of research in midwifery, 2nd edn, Churchill Livingstone, Philadelphia.


Cosminsky, S 1976, 'Birth rituals and symbolism: a Quiché Maya-Black Carib comparison', in P Young & J Howe (eds), Ritual and symbol in Native Central America, University of Oregon, Oregon.


DiCicco-Bloom, B & Crabtree, BF 2006, ‘The qualitative research interview’, Medical 

Dickson-Swift, V, James, EL, Kippen, S, Liamputtong, P 2007, ‘Doing sensitive research: 
what challenges do qualitative researchers face?’ Qualitative Research, vol. 7, no. 3, 
pp. 327-353.

DiMatteo, MR, Kahn, KL & Berry, SH 1993, 'Narratives of birth and the postpartum: 
Analysis of the focus group responses of new mothers', Birth, vol. 4, pp. 204-211.

Dixon, L, Skinner, J & Foureur, M 2012, ‘Women’s perceptions of the stages and phases 

(eds), Reflexivity: a practical guide for researchers in health and social sciences, 

Donnison, J 1988, Midwives and medical men: a history of the struggle for the control of 

Donovan, P 2006, 'Alternative approaches to research', in ER Cluett & R Bluff (eds), 
Principles and practice of research in midwifery, 2nd edn, Churchill Livingstone, pp. 
203-219.

Douglas, M 1966, Purity and danger: an analysis of concepts of pollution and taboo, 
Routledge, London.

Downe, S & McCourt, C 2008, ‘From being to becoming: reconstructing childbirth 
knowledge’, in S Downe (ed), Normal Childbirth: evidence and debate, 2nd edn, 

Downe, S, Simpson, L & Trafford, K 2006, 'Expert intrapartum maternity care: a meta-


East, CE, Dunster, KR & Colditz, PB 1998, 'Fetal oxygen saturation during maternal 
bearing down efforts in the second stage of labour', American Journal of Perinatology, 
vol. 15, no. 2, pp. 121-124.


Emden, C 1998b, 'Theoretical perspectives on narrative inquiry', Collegian, vol. 5, no. 2, 
pp. 30-35.

mothers’ experiences of contact with the labour ward before hospitalisation’, 

Estes, CP 1992, Women who run with the wolves: myths and stories of the wild woman 

Fahy, M Foureur, C Hastie (eds), Birth territory and midwifery guardianship: theory 


Hildingsson, I & Häggström, T 1999, 'Midwives' lived experiences of being supportive to prospective mothers/parents during pregnancy', *Midwifery*, vol. 15, pp. 82-91.


Kent, J 2000, Social perspectives on pregnancy and childbirth for midwives, nurses and the caring professions, The Open University Press.


Kitzinger, S 1979, Women as mothers, Fontana, London.


Leap N 2010, ‘The less we do the more we give’ in M Kirkham (ed), The midwife-mother relationship, 2nd edn, Palgrave: Macmillan, Hampshire.


Low, LK & Moffat, A 2006, ‘Every labor is unique: but “call when your contractions are 3 minutes apart”’, *The American Journal of Maternal/Child Nursing*, vol. 31, no. 5, pp. 307-312.


McHugh, N 1999, ‘Women’s stories… the deep knowledge that is the essence of midwifery knowledge’, Midwifery Matters, vol. 82, no. 3, p.3


Myles, TD & Santolaya, J 2003, 'Maternal and neonatal outcomes in patients with a prolonged second stage of labor', *Obstetrics & Gynecology*, vol. 102, no. 1, pp. 52-58.


Odent, M 2011, Childbirth in the age of plastics, Pinter & Martin, London.


Osborne, K & Hanson, L 2012, 'Directive versus supportive approaches used by midwives when providing care during the second stage', Journal of Midwifery & Women’s Health, vol. 57, no. 1, pp. 3-11.


Parsons, M & Griffiths, R 2007, 'The professional socialization on midwives' practice', Women and Birth, vol. 20, pp. 31-34.


Perry, L & Porter, C 1979, 'Pushing technique and the duration of the second stage of labor', *West Virginia Medical Journal*, vol. 75, no. 2, pp. 32-34.


Polkinghorne, DE 1995, 'Narrative configuration in qualitative analysis', *Qualitative studies in education*, vol. 8, no. 1, pp. 5-23.

Polkinghorne, DE 2007, 'Validity issues in narrative research', *Qualitative Inquiry*, vol. 13, no. 4, pp. 471-486.


Riessman, CK 2003, 'Performing identities in illness narrative', *Qualitative Research*, vol. 3, no. 1, pp. 5-34.


Rogers, MS, Ip, YM, Qin, Y, Rogers, SM & Sahota, D 2003, 'Relationship between umbilical cord morphology and nuchal cord entanglement', *Acta Obstetrica et Gynecologica Scandinavica*, vol. 82, pp. 32-37.


Sque, M 2000, 'Researching the bereaved: an investigator's experience', *Nursing Ethics*, vol. 7, no. 1, pp. 23-34.


Surtees, R 2010, 'Everybody expects the perfect baby… and perfect labour… and so you have to protect yourself': discourses of defence in midwifery practice in Aotearoa/New Zealand', *Nursing Inquiry*, vol. 17, no. 1, pp. 81-91.


Thornburg, P 2002, ""Waiting" as experienced by women hospitalized during the antepartum period", *MCN, American Journal of Maternal/Child Nursing*, vol. 27, no. 4, pp. 245-248.


Thorstensson, S, Nissen, E, Ekström, A 2007, 'An exploration and description of student midwives’ experiences in offering continuous labour support to women/couples', *Midwifery*, doi:10.1016/j.midw.2007.05.003


van Teijlingen, E & Ireland, J 2003, 'Research interviews in midwifery', *Midwives*, vol. 6, no. 6, pp. 260-263.


Waldenströms, U 2004, 'Why do some women change their opinion about childbirth over time?' *Birth*, vol. 31, no. 2, pp. 102-107.


Wickham, S 2003, 'To feel or not to feel?: checking for the nuchal cord', The Practising Midwife, vol. 6, no. 2, p. 27


Wu, RW, Chen, CP & Wang, KG 1996, 'Implications of prolonged fetal heart rate deceleration during the second stage of labor', Journal of the Formosan Association,


Appendices
Appendix A: Ethics approval

From: humanethics
To: Margaret Barnes; mead1@usc.edu.au;
Date: 5/06/2009 2:43 pm
Subject: approval to commence research

Rachel and Margaret

Thank you for the information provided in the last couple of days re satisfying the approval conditions.

You were given approval by the Human Research Ethics Committee for the project “An exploration of midwifery practice during the second stage of labour”, approval number 5/09/210 at the meeting on 19 May, subject to meeting some specific and standard conditions.

You have since revised your proposal and satisfied the specific conditions. On behalf of the Chairperson, I’m informing you that you may commence your research.

Thank you for pointing out the error made re approval to 1 September 2009. This has been corrected to 1 September 2011, and I will send this new letter to you.

Please contact me if there is anything else you would like to discuss.

Regards

Greg Kroggaard
Secretary, Human Research Ethics Committee
Office of Research
University of the Sunshine Coast
Tel: +61 7 5459 4574
Fax: +61 7 5430 1177
Email: humanethics@usc.edu.au
Web: www.usc.edu.au

Regards

Greg Kroggaard
Secretary, Human Research Ethics Committee
Office of Research
University of the Sunshine Coast
Tel: +61 7 5459 4574
Fax: +61 7 5430 1177
Email: humanethics@usc.edu.au
Web: www.usc.edu.au
Appendix B: Invitation to participate - mothers

Invitation to Participate in Research

Project:
An exploration of midwifery practice during the second stage of labour

I am conducting research exploring women’s experience of midwifery care during the second stage of labour as part of my PhD. The reason for this study is that there is very little research looking at practices during the second stage of labour from the perspective of the woman giving birth. Therefore this project aims to talk to women about their birth experiences and discover how they experienced aspects of midwifery care.

Involvement in the project as a participant is voluntary and will involve being interviewed about your birth experience once. I expect that the interview will take between 30 to 60 minutes and can be arranged at a time and venue to suit you.

The research has been approved by the University of the Sunshine Coast Human Research Ethics Committee. The findings of this study will help midwives to understand women’s birth experience and ways in which they can improve care during this time.

To be eligible to participate you would:

- Be English speaking
- Be 18 years of age or over
- Have given birth in the last six months
- Have had a midwife as your main birth attendant (hospital or homebirth)
- Have had an uncomplicated labour and birth without an epidural analgesia
- Have had an unassisted vaginal birth (not ventouse or forceps)

I am very keen to include you in this research, if you are interested and would like further information please contact:

Rachel Reed
Phone: 07 54443751
Mobile: 0412 529 712
Email: reed1@usq.edu.au

USC Ethics Approval No. S/09/210
Appendix C: Invitation to participate – midwives

Invitation to Participate in Research

Project:
An exploration of midwifery practice during the second stage of labour

I am conducting research exploring midwifery practice during the second stage of labour as part of my PhD. The reason for this study is that there is very little research looking at what midwives do during the second stage of labour and the reasons behind particular practices. Therefore this project aims to talk to midwives about their practice during a normal second stage of labour.

Involvement in the project as a participant is voluntary and will involve being interviewed about your midwifery practice. I expect that the interview will take between 30 to 60 minutes and can be arranged at a time and venue to suit you.

The research has been approved by the University of the Sunshine Coast Human Research Ethics Committee. The findings of this study will help midwives to understand midwifery practice during birth.

To be eligible to participate you would:

- Be a midwife
- Be English speaking
- Have cared for a woman/women during a normal second stage of labour (without an epidural) in the last six months

I am very keen to include you in this research, if you are interested and would like further information please contact:

Rachel Reed
Phone: 07 54443751
Mobile: 0412 529 712
Email: rreed1@usc.edu.au

USC Ethics Approval No. SI/09/210
Appendix D:
Participant information sheet - mothers

Research Project Information Sheet

Project:
An exploration midwifery practice during the second stage of labour
USC Ethics Approval No. S/09/210

Principal Researcher: Rachel Reed
Phone: 07 5444 3751
Mobile: 0412 529 712
Email: reed1@usc.edu.au

Dear Participant,

Thank you for considering being involved in this project. Please take your time to think about whether you wish to participate. After taking time to think about participating, please contact the Rachel Reed via phone or email.

Most importantly, involvement in this project is voluntary and if you decide not to participate, this will not lead to any penalty. You may discontinue your participation at any time without penalty and with no need for explanation.

If you have any complaints about the way this research project is being conducted you can either raise them with the Principal Researcher or, if you prefer an independent person, contact the Chairperson of the Human Research Ethics Committee of the University of the Sunshine Coast: (c/o The Academic Administration Officer, Teaching and Research Services, University of the Sunshine Coast, Maroochydore DC 4558; telephone (07) 5459 4574; facsimile (07) 5459 4727; email: humanethics@usc.edu.au)

About the project.
A woman’s birth experience is important, however there has been relatively little research in this area. Midwives practice during the second stage of labour (the birth of the baby) may influence women’s experience of their birth. This project aims to talk to women about their birth and discover how they experienced aspects of midwifery care. The findings of this study will help midwives to understand women’s birth experiences and ways in which they can improve care during this time.

What your participation in the project will involve
Involvement in the project as a participant is voluntary and will involve being interviewed about your birth experience once. I expect that the interview will take between 30 to 60 minutes and can be arranged at a time and venue to suit you. During the interview you will be asked to tell me your birth story in your own words.
The interview will be taped and you will have the opportunity to read the transcript of the interview if you wish.

To be eligible to participate you would need to:

- Be English speaking
- Be 18 years of age or over
- Have given birth in the last six months
- Have had a midwife as your main birth attendant (hospital or homebirth)
- Have had an uncomplicated labour and birth
- Have had an unassisted vaginal birth (not ventouse or forceps)

Benefits and Risks

The results of this research will help midwives to understand women’s birth experiences and ways in which they can improve their practice and care. This will benefit women in the future. You may benefit as a participant, by having the opportunity to discuss issues and concerns at the time of the interview.

There is the potential, however, for you to become uncomfortable or emotionally distressed by recounting your experience of birth. The person who will conduct the interview is an experienced midwife who has the skills to identify your concern and assist at the time and refer you for additional support if necessary. Such support could include referral to your medical practitioner or a psychologist.

All information collected during the interview will remain confidential, and anonymous. Information (tapes and transcripts) will be coded so that your identity will not be evident, and all data, transcripts and tapes will be securely stored at the University of the Sunshine Coast. Data collected will only be used for the purpose of this research or directly related research. If you decide to discontinue your involvement in the project all data collected from you will not be used in the project.

Results of the research will be disseminated via a PhD thesis, conference papers and published articles. In these documents there may be extracts from your taped interview, however these will remain anonymous. Feedback about the project will be provided to you through a summary report.

The research is being conducted as part of a PhD undertaken at the University of the Sunshine Coast. The study has been approved by the University of the Sunshine Coast Human Research Ethics Committee. The researcher does not anticipate there will be any commercial exploitation from the research.

The research team comprises of Rachel Reed a midwife and PhD student supported by academics with experience in the research method being used.

We appreciate your assistance and contribution to this research. If you have any further questions or concern about the research please contact the Principal Researcher Rachel Reed – 07 5444 3751 or email: reed1@usc.edu.au
Research Team

Rachel Reed (Principal Researcher)
Lecturer
School of Health and Sport Sciences
University of the Sunshine Coast
Locked Bag 4
Maroochydore DC 4558
Phone: 07 5444 3751
Email: reed1@usc.edu.au

Dr Margaret Barnes (Supervisor)
Associate Professor
School of Health and Sport Sciences
University of the Sunshine Coast
Locked Bag 4
Maroochydore DC 4558
Phone: 07 5459 4686
Email: mbarnes@usc.edu.au

Dr Jan Allan (Supervisor)
Associate Professor
School of Health and Sport Sciences
University of the Sunshine Coast
Locked Bag 4
Maroochydore DC 4558
Phone: 07 5459 4834
Email: jallan@usc.edu.au
Appendix E:
Participant information sheet - midwives

Research Project Information Sheet

Project:
An exploration of midwifery practice during the second stage of labour
USC Ethics Approval No. S/09/210

Principal Researcher: Rachel Reed
Phone: 07 5444 3751
Mobile: 0412 529 712
Email: reed1@usc.edu.au

Dear Participant,

Thank you for considering being involved in this project. Please take your time to think about whether you wish to participate. After taking time to think about participating, please contact Rachel Reed via phone or email.

Most importantly, involvement in this project is voluntary and if you decide not to participate, this will not lead to any penalty. You may discontinue your participation at any time without penalty and with no need for explanation.

If you have any complaints about the way this research project is being conducted you can either raise them with the Principal Researcher or, if you prefer an independent person, contact the Chairperson of the Human Research Ethics Committee of the University of the Sunshine Coast; (c/o The Academic Administration Officer, Teaching and Research Services, University of the Sunshine Coast, Maroochydore DC 4558), telephone (07) 5459 4574; facsimile (07) 5459 4727; email: humanethics@usc.edu.au

About the project.
Midwives practice during the second stage of labour (the birth of the baby) may influence women’s experience of their birth. There is very little research looking at what midwives do during the second stage of labour and the reasons behind particular practices. Therefore this project aims to talk to midwives about their practice during a normal second stage of labour, and talk to women about how they experience midwifery care. The findings of this study will help midwives to understand women’s birth experiences and ways in which they can improve care during this time.

What your participation in the project will involve
Involvement in the project as a participant is voluntary and will involve being interviewed about your practice during a normal second stage, I expect that the
interview will take between 30 to 60 minutes and can be arranged at a time and
venue to suit you. During the interview you will be asked to tell me a recent birth story
in which you were the main birth attendant. The interview will be taped and you will
have the opportunity to read the transcript of the interview if you wish.

To be eligible to participate you would need to:

- Be a midwife
- Be English speaking
- Have cared for a woman/women during a normal second stage of labour
  (without an epidural) in the last six months

Benefits and Risks

The results of this research will help midwives to understand women’s birth
experiences and ways in which their care influences this experience. This will benefit
women and midwives in the future. You may benefit as a participant, by having the
opportunity to discuss your practice, issues and concerns at the time of the interview.

There is the potential, however, for you to become uncomfortable or emotionally
distressed by recounting your experiences. The person who will conduct the
interview is an experienced midwife who has the skills to identify your concern and
assist at the time and refer you for additional support if necessary. Such support
could include referral to your medical practitioner or a psychologist.

All information collected during the interview will remain confidential, and anonymous.
Information (tapes and transcripts) will be coded so that your identity will not be
evident, and all data, transcripts and tapes will be securely stored at the University of
the Sunshine Coast. Data collected will only be used for the purpose of this research
or directly related research. If you decide to discontinue your involvement in the
project all data collected from you will not be used in the project.

Results of the research will be disseminated via a PhD thesis, conference papers
and published articles. In these documents there may be extracts from your taped
interview, however these will remain anonymous. Feedback about the project will be
provided to you through a summary report.

The research is being conducted as part of a PhD undertaken at the University of the
Sunshine Coast. The study has been approved by the University of the Sunshine
Coast Human Research Ethics Committee. The researcher does not anticipate there
will be any commercial exploitation from the research.

The research team comprises of Rachel Reed a midwife and PhD student supported
by academics with experience in the research method being used.

We appreciate your assistance and contribution to this research. If you have any
further questions or concern about the research please contact the Principal
Researcher Rachel Reed – 07 5444 3751 or email: reed1@usc.edu.au
Research Team

Rachel Reed (Principal Researcher)
Lecturer
School of Health and Sport Sciences
University of the Sunshine Coast
Locked Bag 4
Maroochydore DC 4558
Phone: 07 5444 3751
Email: reed1@usc.edu.au

Dr Margaret Barnes (Supervisor)
Associate Professor
School of Health and Sport Sciences
University of the Sunshine Coast
Locked Bag 4
Maroochydore DC 4558
Phone: 07 5459 4686
Email: mbarnes@usc.edu.au

Dr Jan Allan (Supervisor)
Associate Professor
School of Health and Sport Sciences
University of the Sunshine Coast
Locked Bag 4
Maroochydore DC 4558
Phone: 07 5459 4834
Email: jallan@usc.edu.au
Appendix F:
Participant consent form - mothers

Consent to Participate in Research

Project:
An exploration of midwifery practice during the second stage of labour
USC Ethics Approval No. 5/09/210

Principal Researcher: Rachel Reed
Phone: 07 5444 3751
Mobile: 0412 529 712
Email: reed1@usc.edu.au

Project Overview
A woman’s birth experience is important, however there has been relatively little research in this area. Midwives practice during the second stage of labour (the birth of the baby) may influence women’s experience of their birth. This project aims to talk to women about their birth and discover how they experienced aspects of midwifery care. The findings of this study will help midwives to understand women’s birth experiences and ways in which they can improve care.

I understand that:

- I do not have to participate in this research study if I do not want to; and
- I can withdraw from the study at any time and I do not have to give an reason for withdrawing; and
- If I do choose to withdraw from the research study at any time, any information received from me or pertaining to me that was obtained during the research will not be used; and
- I will not be penalised or treated less favourably or lose any benefit if I do withdraw from the study.
- I understand that I will be provided with a summary of the results of the research
- I understand that all information obtained from me or pertaining to me will be kept strictly confidential to the research team and that there will be no means of identifying me personally as a research participant in any publication, presentation or other means arising from the research.
- I understand that data collected will only be used for the purpose of this research or directly related research.
- I understand the contents of the Research Project Information Sheet for the research study “An exploration of routine midwifery interventions during the second stage of labour – midwives' practice and women's experience” and this Consent to Participate in Research form. I agree to participate in the project and give my consent freely. I understand that the project will be
carried out as described on the Research Project Information Sheet, a copy of which I have kept. I realise that whether or not I decide to participate is my decision and will not affect my care or treatment. I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. Any questions I had about this research project and my participation in it have been answered to my satisfaction.

Participant Name:........................................... Date:.........................

Participant Signature:......................................

Researcher Name:........................................... Date:.........................

Researcher Signature:.....................................
Appendix G:
Participant consent form - midwives

Consent to Participate in Research

Project:
An exploration of midwifery practice during the second stage of labour
USC Ethics Approval No. S/09/210

Principal Researcher: Rachel Reed
Phone: 07 5444 3751
Mobile: 0412 529 712
Email: reed1@usc.edu.au

Project Overview
Midwives practice during the second stage of labour (the birth of the baby) may influence women’s experience of their birth. There is very little research looking at what midwives do during the second stage of labour and the reasons behind particular practices. Therefore this project aims to talk to midwives about their practice during a normal second stage of labour, and talk to women about how they experience midwifery care. The findings of this study will help midwives to understand women’s birth experiences and ways in which they can improve care during this time.

I understand that:

• I do not have to participate in this research study if I do not want to; and
• I can withdraw from the study at any time and I do not have to give an reason for withdrawing; and
• If I do choose to withdraw from the research study at any time, any information received from me or pertaining to me that was obtained during the research will not be used; and
• I will not be penalised or treated less favourably or lose any benefit if I do withdraw from the study.
• I understand that I will be provided with a summary of the results of the research
• I understand that all information obtained from me or pertaining to me will be kept strictly confidential to the research team and that there will be no means of identifying me personally as a research participant in any publication, presentation or other means arising from the research.
• I understand that data collected will only be used for the purpose of this research or directly related research.
• I understand the contents of the Research Project Information Sheet for the research study “An exploration of midwifery practice during the second stage of labour” and this Consent to Participate in Research form. I agree to
participate in the project and give my consent freely. I understand that the project will be carried out as described on the Research Project Information Sheet, a copy of which I have kept. I realise that whether or not I decide to participate is my decision and will not affect my care or treatment. I also realise that I can withdraw from the study at any time and that I do not have to give any reasons for withdrawing. Any questions I had about this research project and my participation in it have been answered to my satisfaction.

Participant Name: ........................................... Date: ..........................

Participant Signature: ........................................

Researcher Name: ........................................... Date: ..........................

Researcher Signature: ........................................
Appendix H: Guidelines for interviewing new mothers

Callister’s (2004, p. 513) Guidelines for interviewing new mothers in clinical settings

- Ask open-minded questions, such as “What was your experience like?”
- Emphasize there are no right or wrong answers – her perspectives are what is important.
- Respond to the mother’s comments with statements such as “How was that for you?” or “Can you give me an example?”
- Actively listen in a reflective, empathetic way.
- Accept that some mothers may share the entire experience without prompting; others will need probing questions.
- If the mother expresses frustration, sadness, or confusion, gently clarify why an intervention or action may have been necessary and affirm you can understand why it was challenging and perhaps confusing to her.
- Accept that a woman may need to vent if she is feeling overwhelmed or angry.
- Allow the mother to become emotional and express tender feelings and emotions about her experience, rather than focusing on “the facts” of her birth.
- Allow the mother to express her perceptions of personal failures, and then help her identify strengths, endurance, or unique coping mechanisms, focusing on positive affirmation.
- Gain important information on what the mother would do differently with her next birth, what she wants from birth experiences in the future, or health care interventions that were supportive or nonsupportive.

Adapted from Charles and Curtis (1994), Kalman and Ancheta (1997), and Nichols (1996)
Appendix I:
Framework for appraising the quality of qualitative research

Walsh and Downe’s (2006, pp. 114-115) Framework for appraising the quality of qualitative research

<table>
<thead>
<tr>
<th>Stages</th>
<th>Essential Criteria</th>
<th>Specific Prompts</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scope and purpose</strong></td>
<td>Clear statement of, and rationale for, research question/aims/purposes</td>
<td>• Clarity of focus demonstrated                                                                                     • Explicit purpose given, such as descriptive/explanatory intent, theory building, hypothesis testing • Link between research and existing knowledge demonstrated</td>
</tr>
<tr>
<td></td>
<td>Study thoroughly contextualised by existing literature</td>
<td>• Evidence of systematic approach to literature review, location of literature to contextualise the findings, or both</td>
</tr>
<tr>
<td><strong>Design</strong></td>
<td>Method/design apparent, and consistent with research intent</td>
<td>• Rationale given for use of qualitative design                                                                                                             • Discussion of epistemological/ontological grounding • Rationale explored for specific qualitative method (e.g. ethnography, grounded theory, phenomenology) • Discussion of why particular method chosen is most appropriate/sensitive/relevant for research question/aims • Setting appropriate</td>
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<tr>
<td></td>
<td>Data collection strategy apparent and appropriate</td>
<td>• Were data collection methods appropriate for type of data required and for specific qualitative method?                                                                                                             • Were they likely to capture the complexity/diversity of experience and illuminate context in sufficient detail? • Was triangulation of data sources used if appropriate?</td>
</tr>
<tr>
<td><strong>Sampling strategy</strong></td>
<td>Sample and sampling method appropriate</td>
<td>• Selection criteria detailed, and description of how sampling was undertaken                                                                                                                                   • Justification for sampling strategy given • Thickness of description likely to be achieved from sampling • Any disparity between planned and actual sample explained</td>
</tr>
<tr>
<td><strong>Analysis</strong></td>
<td>Analytic approach appropriate</td>
<td>• Approach made explicit (e.g. Thematic distillation, constant comparative method, grounded theory)</td>
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<tr>
<td>Appendices</td>
<td></td>
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<tr>
<td><strong>Interpretation</strong></td>
<td>Context described and taken account of in interpretation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Description of social/physical and interpersonal contexts of data collection</td>
<td></td>
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<tr>
<td></td>
<td>• Evidence that researcher spent time ‘dwelling with the data’, interrogating it for competing/alternative explanations of phenomena</td>
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<tr>
<td></td>
<td>Clear audit trail given</td>
<td></td>
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<td></td>
<td>• Sufficient discussion of research processes such that others can follow ‘decision trail’</td>
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<tr>
<td></td>
<td>Data used to support interpretation</td>
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</tr>
<tr>
<td></td>
<td>• Extensive use of field notes entries/verbatim interview quotes in discussion of findings</td>
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<tr>
<td></td>
<td>• Clear exposition of how interpretation led to conclusions</td>
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<tr>
<td><strong>Reflexivity</strong></td>
<td>Researcher reflexivity demonstrated</td>
<td></td>
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<tr>
<td></td>
<td>• Discussion of relationship between researcher and participants during fieldwork</td>
<td></td>
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<tr>
<td></td>
<td>• Demonstration of researcher’s influence on stages of research process</td>
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<td></td>
<td>• Evidence of self-awareness/insight</td>
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<td></td>
<td>• Documentation of effects of the research on researcher</td>
<td></td>
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<td></td>
<td>• Evidence of how problems/complications met were dealt with</td>
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<tr>
<td><strong>Ethical dimensions</strong></td>
<td>Demonstration of sensitivity to ethical concerns</td>
<td></td>
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<tr>
<td></td>
<td>• Ethical committee approval granted</td>
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<td></td>
<td>• Clear commitment to integrity, honesty, transparency, equality and mutual respect in relationships with participants</td>
<td></td>
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<tr>
<td></td>
<td>• Evidence of fair dealing with all research participants</td>
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</tr>
<tr>
<td></td>
<td>• Recording of dilemmas met and how resolved in relation to ethical issues</td>
<td></td>
</tr>
</tbody>
</table>
| | • Documentation of how autonomy,
Relevance and transferability | Relevance and transferability evident | • Sufficient evidence for typicality specificity to be assessed  
• Analysis interwoven with existing theories and other relevant explanatory literature drawn from similar settings and studies  
• Discussion of how explanatory propositions/emergent theory may fit other contexts  
• Limitations/weaknesses of study clearly outlined  
• Clearly resonates with other knowledge and experience  
• Results/conclusions obviously supported by evidence  
• Interpretation plausible and 'makes sense'  
• Provides new insights and increases understanding  
• Significance for current policy and practice outlined  
• Assessment of value/empowerment for participants  
• Outlines further directions for investigation  
• Comment on whether aims/purposes of research were achieved

consent, confidentiality, anonymity were managed