

# **Perceptions of the Midwife's Role: A Feminist Technoscience Perspective**

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**A Thesis submitted in part fulfilment for the requirements of the  
Degree of Doctor of Philosophy at the University of Central  
Lancashire.**

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# Perceptions of the Midwife's Role: A Feminist Technoscience Perspective

## ABSTRACT

Different patterns of care and a range of lead professionals have influenced care provision in relation to childbirth. The role of a midwife has been influenced by historical factors, research and service changes within the National Health Service. Little is known about how the role of the midwife is perceived. This study explored the views of women and midwives relating to the role of the midwife.

Mixed methods of data collection were utilised. In the first phase of the study 4 focus groups (a total of 9 women) were performed. In the second phase of the study longitudinal interviews were conducted. A total of 10 women participated in this phase. The interviews were performed at 4 different time points of their childbearing experience. A total of 40 interviews were conducted. Additionally diaries from the 10 women were completed, to capture information between the interview time points. Following the initial exploratory phase<sup>1</sup>, a postmodern feminist technoscience theoretical stance underpins the second phase of this study; in particular it draws on the work of Donna Haraway. Haraway's notion of 'situated knowledges' provides the opportunity to locate the views of women and midwives. This provided the opportunity to utilise her notions of 'modest witness', 'cyborg', 'goddess', 'material-semiotic' and connect to their perceptions.

One facet of the study's originality lies in matching the women's and midwives' 'situated knowledges', by interviewing the 10 midwives who were present at each of the 10 women's birth experiences. Analysis using thematic networks was used to construct basic, organising and global themes.

The findings indicate that the use of technology has a powerful influence on women's perceptions in relation to the role of the midwife. Women and midwives connected with technology through material-semiotic connections, which has led to cyborgification within a consultant led model of care and birth

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<sup>1</sup> The exploratory phase was the first phase of this study.

environment. Women overwhelmingly perceived that birth was safer in hospital, due to the presence of technology and doctors; doctors were perceived as the decision maker and the midwife as a 'handmaiden'.

'Being' and 'doing' midwives were recognised. The midwives were all situated in a different place within these categories, depending on their values and experiences. Generally the 'doing' midwives were free to 'do', as they supported the biomedical culture of the environment they were working in. 'Being' midwives supported the natural elements of the birth process, they adapted to the role of a 'hybrid' midwife within a consultant led environment, interchanging their technological skills for normality skills when they were secluded from interferences of the medicalised culture.

This study provides evidence to inform practice developments within midwifery and makes a contribution to feminist theorising. It asserts that the culture of childbirth in contemporary society is technological, medically led and the normal birth process is not valued. This has contributed to cyborgification of women and midwives within a consultant led setting. An advancement of Haraway's theory has been made from the emergence of the way in which the 'being' midwife morphs into a 'doing' midwife when she feels that she has to conform to the medicalised culture of the environment or from women's expectations of their birth experience.

<b>CONTENTS</b>		<b>Page</b>
	STUDENT DECLARATION.	2
	PERMISSION TO COPY.	2
	ABSTRACT.	3
	LIST OF CONTENTS.	5
	LIST OF FIGURES AND TABLES.	12
	STATEMENT OF CONTRIBUTION.	13
	ACKNOWLEDGEMENTS.	14
	GLOSSARY OF TERMS.	15
<b>1</b>	<b><u>CHAPTER 1:</u></b>	
	<b><u>INTRODUCING THE THESIS AND RESEARCH.</u></b>	
1.1	INTRODUCTION.	16
1.2	FOCUS OF THE RESEARCH AND THESIS.	16
1.3	AIMS AND OBJECTIVES OF THE RESEARCH.	17
1.4	METHODOLOGICAL APPROACHES TO THE RESEARCH AND THESIS.	18
1.5	STYLE OF THE THESIS.	19
1.6	STRUCTURE OF THE THESIS.	20
1.7	CONCLUSION.	21
<b>2</b>	<b><u>CHAPTER 2:</u></b>	
	<b><u>PERCEPTIONS OF THE MIDWIFE'S ROLE: WHAT HAS INFLUENCED WOMEN AND MIDWIVES KNOWLEDGE.</u></b>	
2.1	<u>INTRODUCTION.</u>	22
2.2	<u>SECTION 1: BACKGROUND.</u>	23
2.2.1	INTRODUCTION.	23
2.2.2	DEFINITION OF THE ROLE OF A MIDWIFE.	23
2.2.3	MEDICALISATION OF BIRTH.	27
2.2.4	CURRENT MIDWIFERY POLICY.	29
2.2.5	THE HISTORICAL ROLE OF THE MIDWIFE-	32

---

2.2.5.1	Traditional birth.	32
2.2.5.2	Male Influence on birth.	33
2.2.5.3	Male midwives.	33
2.2.5.4	Professionalisation of the midwife.	36
2.2.5.5	The move from home to hospital.	36
2.2.5.6	The emergence of technocratic birth.	37
2.2.5.7	Turning the tide.	40
2.2.6	THE IMPACT OF TECHNOCRATIC BIRTH ON THE ROLE OF THE MIDWIFE-	41
2.2.6.1	Institutional control.	41
2.2.7	HOLISTIC BIRTH.	43
2.2.8	CONCLUSION.	46
2.3	<u>SECTION 2: LITERATURE REVIEW.</u>	47
2.3.1	INTRODUCTION.	47
2.3.2	HOW MIDWIVES VIEW THEIR ROLE.	49
2.3.2.1	Midwives working within different models of care.	54
2.3.3	HOW WOMEN PERCIEVE THE MIDWIFE'S ROLE.	60
2.3.4	PARTNERS PERCEPTIONS OF THE MIDWIFE'S ROLE.	64
2.3.5	CONCLUSION.	67
2.4	<u>CHAPTER CONCLUSION.</u>	84
3	<u>CHAPTER 3:</u> <u>METHODOLOGY OF THE FIRST PHASE.</u>	
3.1	INTRODUCTION.	86
3.2	FEMINIST PERSPECTIVES; CHOOSING A PATH.	87
3.2.1	Defining Feminist Theory.	87
3.2.2	First Wave: Recognition of Inequality.	88
3.2.3	Second Wave: Different Perspectives of Seeing-	90
3.2.3.1	Liberal feminism.	90
3.2.3.2	Radical feminism.	95
3.2.3.3	Marxist and socialist feminism.	95
3.2.3.4	Psychoanalytic feminism.	97
3.2.3.5	Postmodernism/ Postmodern feminism.	100
3.2.4	Third Wave: Seeing with 3D spectacles.	101
3.3	ETHICAL CONSIDERATIONS.	104

---

---

3.3.1	Harm.	104
3.3.2	Consent.	105
3.3.3	Confidentiality.	106
3.3.4	Ethical committee experience.	106
3.4	RESEARCH DESIGN.	107
3.4.1	Sample.	107
3.4.2	Recruitment.	108
3.4.3	Reflexivity.	109
3.4.4	The start of my journey	109
3.4.5	Method.	110
3.4.6	Aim.	111
3.4.7	Moderation.	112
3.4.8	Analysis of the data.	112
3.4.9	Member checking.	113
3.5	CONCLUSION.	113
4	<u>CHAPTER 4:</u>	
	<u>METHODOLOGY OF THE SECOND PHASE.</u>	
4.1	INTRODUCTION.	115
4.2	FEMINIST THEORIES AND THE ROLE OF THE MIDWIFE.	116
4.3	WOMEN AND INTERPRETATIONS OF THE MEDIA.	125
4.4	BODIES AND IMAGERY OF BIRTH.	126
4.5	UNDERSTANDING PERCEPTIONS OF THE MIDWIFE'S ROLE; HOW CAN HARAWAY HELP?	132
4.6	THE INFLUENCE OF THE THEORETICAL PERSPECTIVE ON THE METHODOLOGY.	139
4.6.1	Ontology: Seeing from a woman's vantage point.	139
4.6.2	A new way to see.	140
4.6.3	To sweep or not to sweep? Feminist epistemology versus postmodern thought.	140
4.6.4	What Is true and what Is valid?	142
4.6.5	Situating myself and recognising my diffractions.	145
4.6.6	Recognising 'difference'.	145
4.6.7	Centering myself.	146
4.7	ETHICAL PRINCIPLES.	147

---

---

4.7.1	Harm.	147
4.7.2	Consent.	147
4.7.3	Confidentiality.	147
4.7.4	My ethics committee experience.	148
4.8	RESEARCH DESIGN.	148
4.8.1	Sample.	148
4.8.2	Recruitment.	149
4.8.3	Methods.	150
4.8.4	Aims and objectives.	151
4.8.5	Moderation.	151
4.8.6	Member checking.	151
4.9	DATA MANAGEMENT ANALYSIS	152
4.9.1	Data analysis.	155
4.10	CONCLUSION.	157
5	<u>CHAPTER 5: AN INITIAL EXPLORATION OF WOMEN'S THOUGHTS ON WHAT A MIDWIFE DOES.</u>	
5.1	INTRODUCTION.	160
5.2	INVESTIGATING WOMENS PERCEPTIONS.	161
5.3	WOMEN'S VIEWS ON THE ROLE OF THE MIDWIFE-	162
5.3.1	Midwives' Influence on women's empowerment.	162
5.3.2	The Influence of media, family and friends on women's views of the role of a midwife.	164
5.3.3	Technology and monitoring: How women come to know what a midwife does.	166
5.3.4	How women perceive the role of the doctor, in contrast to the role of the midwife.	169
5.4	CONCLUSION.	171
6	<u>CHAPTER 6: WHAT A MIDWIFE DOES: SITUATED KNOWLEDGES OF WOMEN AND MIDWIVES.</u>	
6.1	INTRODUCTION.	174
6.2	DEMOGRAPHIC DATA OF THE PARTICIPANTS.	174
6.3	WOMEN'S THEMES; DISCOVERING WOMEN'S 'SITUATED KNOWLEDGES'.	177

---



---

6.3.1	Women do not understand physiological birth.	179
6.3.2	Doctors make the decisions.	185
6.3.3	Technology is necessary/ needed in childbirth.	188
6.4	MIDWIVES' THEMES: MIDWIVES KNOWLEDGE CONSTRUCTION.	190
6.4.1	Focus is on midwives 'doing' rather than 'being'.	192
6.4.2	Technocratic medicalised birth culture constrains practice of midwives.	195
6.4.3	Significant value placed on technology in pregnancy, labour and birth.	198
6.5	MATCHING 'SITUATED KNOWLEDGES' OF WOMEN AND MIDWIVES.	200
6.5.1	Women do not understand physiological birth (womens themes). Focus on midwives 'doing' rather than 'being' (midwives themes).	202
6.5.2	Doctors make the decisions (women's themes). Technocratic medicalised birth culture constrains practice of midwives supporting normal physiological birth (midwives' themes).	209
6.5.3	Technology is Needed/ Necessary for Childbirth (womens and midwives themes)	212
6.6	CONCLUSION	218
7	<u>CHAPTER 7:</u> <u>DISCUSSION; A TECHNOSCIENCE PERSPECTIVE.</u>	
7.1	INTRODUCTION.	223
7.2	ORIGINAL KNOWLEDGE PROVIDED BY THIS STUDY.	224
7.2.1	Understanding physiological birth: Where women are situated.	224
7.2.2	Midwives Influence on women's empowerment: A key to engagement.	226
7.2.3	Technology: A necessary tool for childbirth.	230
7.2.4	The lie of the land: doctors are the decision makers within the	230

---

---

	technocratic medicalised birth culture.	
7.2.5	The focus of maternity care in society is medically led, technological and the normal birth process is not valued.	231
7.3	SIMILARITIES TO EXISTING KNOWLEDGE.	232
7.3.1	The technocratic medicalised birth culture: It's relationship with how midwives practice.	232
7.3.2	Authoritative knowledge.	236
7.3.3	Media Interpretations of childbirth: Influences on perceptions of a midwife's role.	237
7.3.4	Valuing the normal physiological birth process.	238
7.3.5	The value of technology.	239
7.3.6	What women Interpret as making birth safe?	242
7.4	HOW HARAWAY HELPS US TO UNDERSTAND PERCEPTIONS OF A MIDWIFE'S ROLE.	243
7.4.1	Modest witness.	243
7.4.2	Material- semiotic.	246
7.4.3	Cyborg.	246
7.5	CONCEPTUALISATIONS OF A MIDWIFE'S ROLE.	250
7.6	STRENGTHS AND LIMITATIONS OF THIS STUDY.	253
7.7	CONCLUSION.	255
8	CHAPTER 8: FINDING THE WAY FORWARD.	
8.1	INTRODUCTION	260
8.2	TAKING ELEMENTS FROM THIS THESIS FORWARD.	260
8.2.1	Midwives leading care: A key to women's empowerment.	260
8.3	INFLUENCING THE POLITICAL AGENDA.	261
8.4	MAKING A DIFFERENCE.	264
8.5	FUTURE RESEARCH.	265
8.6	OUTCOME FROM THE STUDY.	266
8.6.1	Technology: A vehicle for influencing a change in perceptions.	266
8.7	CONCLUSION	267
9	REFERENCES.	273
10	APPENDICES.	294

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10.1	Appendix 1- Information Sheet, Consent Form, Interview Schedule and confirmation of ethic's committee approval for first phase of research.	295
10.2	Appendix 2- Information sheet, consent form Interview schedule and confirmation of ethic's committee approval for second phase of research.	296
10.3	Appendix 3- Women and midwives matched cases from the second phase of research.	303
10.4	Appendix 4-Awards, presentations, publications.	307
10.5	Appendix 5- Examples of: Interview transcripts from second phase of research, thematic analysis of the first and second phase.	309
10.6	Appendix 6- DVD 'from bump to baby', Intellectual property confirmation and website information acknowledging research.	310

---

FIGURES AND TABLES		Page
GLOSSARY.		
0.1	Glossary of terms.	15
CHAPTER 2.		
2.1	Models of childbirth.	39
2.3.4.1	Midwives' Views of Their Role.	69
2.3.4.2	Midwives working in different models of care.	73
2.3.4.3	How women perceive the midwife's role.	76
2.3.4.4	Partner's perceptions of the midwife's role.	82
2.3.4.5	Research journey.	85
CHAPTER 3.		
3.1	Phase one participants.	108
3.2	Research journey.	114
CHAPTER 4.		
4.1	Thematic networks analysis.	154
4.2	Research journey.	159
CHAPTER 5.		
5.1	Research journey.	173
CHAPTER 6.		
6.1	The women.	175
6.2	The midwives.	176
6.3	Women's themes.	178
6.4	Midwives' themes.	191
6.5	Combined themes.	201
6.6	Women and midwives combined themes.	220
6.7	Research journey.	221
CHAPTER 7.		
7.1	Relating Laschinger et al's model to midwifery practice.	229
7.2	Research journey.	257
CHAPTER 8.		
8.1	Research journey.	270

## **STATEMENT OF CONTRIBUTION**

My application of a postmodern feminist technoscience perspective to women's and midwives' perceptions of the midwife's role provides a unique insight into their 'situated knowledges'. This thesis will help inform midwifery practice developments and makes a contribution to feminist theorising. It does this by advancing Haraway's theory of the 'modest witness'. Midwives practicing within 'being' values in a medicalised technocratic environment were discovered as adapting to the culture and women's expectations about their childbearing experience. A process of cyborgification occurred for them to become 'doing' midwives, when they perceived that they were pressurised to conform to these influences.

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## GLOSSARY OF TERMS USED

Terms used in this Chapter, in reference to women and midwives' quotations from transcriptions are in figure 0.1 below:

Figure 0.1: Glossary of Terms

Term	Explanation
MLC	Midwifery led care. Women experiencing care led by a midwife. She does not need to have contact with a doctor unless any problems occur.
CLC	Consultant led care. Women experiencing care led by a consultant obstetrician. Generally women are seen throughout their pregnancy at the hospital by the consultant obstetrician or another doctor.
A/N	Antenatal period. This is the woman's pregnancy, up until the point of birth.
P/N	Postnatal period. This is the time after the baby is born up until around 28 days, but this is extended if women need midwifery care after this time.
Multip	Multigravida. This is a woman who has had more than one pregnancy.
Primip	Primigravida. This is a woman who is in her first pregnancy.
CTG	Cardiotocograph. This is a machine used to monitor women's contractions and her baby's heartbeat over a continuous period. It provides a continuous graph of both readings on paper.
ARM	Artificial rupture of membranes. This involves an amnihook being used by a doctor or a midwife to break the amniotic membrane (bag of fluid surrounding the baby), which is inserted up through the vagina and is similar to a crochet hook.

## **CHAPTER 1**

### **INTRODUCING THE THESIS AND RESEARCH**

#### **1.1 INTRODUCTION**

This first chapter provides an overview of this thesis and outlines the focus and context of the research. It outlines the aims, objectives and methodology of the study, while also locating its structure.

#### **1.2 FOCUS OF THE RESEARCH AND THESIS**

This thesis explores perceptions of the role of the midwife. An initial exploration was made, which has informed a deeper investigation in the second phase of this study. The findings are investigated through a feminist technoscience 'lens' to provide an in depth understanding to inform practice developments within midwifery and make a contribution to the evolving field of feminist technoscience theorising.

Historically the role of the midwife has evolved and diversified in relation to care provision, yet the impact of this on perceptions of the role is unclear. Research into how midwives view their role (Lavender et al 2001,2002), suggests that while role extension can increase continuity of carer, it can also devalue midwifery practice. Furthermore, it has been suggested that women are unclear of the midwife's role (Lavender and Chapple 2002, Houghton et al. 2008). Historical factors, research and service changes within maternity care in the U.K have influenced this changing role of the midwife and have therefore impacted on subsequent perceptions.



### **1.3 AIMS AND OBJECTIVES OF THE RESEARCH**

The aim of this study was to explore perceptions of the role of the midwife from the perspective of both women and their supporting midwives, to provide deeper insights to inform practice developments within midwifery and to make a contribution to feminist theorising. A feminist technoscience theoretical stance underpins the empirical components of the second phase of this study; in particular the work of Donna Haraway (1988, 1991, 1997).

There were two distinct empirical phases. The objectives of phase one were:

- To explore how women perceived the role of the midwife.
- To identify if women perceived the role differently relating to: if it was their first pregnancy or subsequent pregnancies; if they were in their pregnancy or following the birth; if they were in a different model of care, having a birth experience in different birth environments.

The findings from phase one were used as a basis to explore perceptions of the midwife's role in a consultant led setting.

The objectives of phase two were:

- To explore how women receiving consultant led care view the role of the midwife through their pregnancy, birth and the post-natal period.
- To compare the woman's perceptions to how the midwife perceives herself in relation to the identified themes.

## **1.4 METHODOLOGICAL APPROACH TO THE RESEARCH AND THESIS**

The initial phase of this study utilised focus groups as the method of data collection. An interpretive thematic analysis of the transcripts identified four emerging themes: midwives influence on women's empowerment; influences of media, friends and family; role of monitoring and technology; influence of doctors.

My methodology for phase 2 developed following the identification of themes in the first phase of the research, this is discussed in chapter 3, and then developed further following identification of a theoretical direction. The second phase was guided by Haraway's (1988, 1991,1997) theories, especially her principles of 'situated knowledges' and diffraction, which are explained in chapter 4. In this phase I have also drawn on the work of Attride- Stirling's (2001) to develop thematic analysis networks to assist the organisation of themes extracted from the data.

In the second phase of the research the samples consisted of women receiving consultant led care who are primigravida. In depth interviews were performed at two stages in the pregnancy and two stages in the post-natal period to explore further the themes identified in phase one. The women were also given diaries to record interactions with midwives throughout their journey. An in-depth interview was also performed with the midwife who was in attendance when the woman gave birth, to explore the themes further from phase one in relation to a midwife's view and compare the woman's birth experience. This provides a mixture of qualitative material, to provide a more comprehensive understanding of perceptions of the midwife's role.

One facet of the study's originality lies in the matching of the women's and midwives' 'situated knowledges' that provide 'mirroring' of the perceptions found relating to the role of the midwife. I have not identified any other study exploring the role of the midwife in which the views of both the woman and the midwife have been explored.

## 1.5 STYLE OF THE THESIS

This thesis is written without divorcing the text from my own personal and professional experiences; it is therefore appropriate to write in the first person. Stanley (1992; 1993) has advocated that the use of the first person can make clear the author's position within the research, while others view this style as contentious (Okely 1992). In the first phase of the study I did use reflexivity to acknowledge my values and beliefs and made an attempt to 'bracket' my views and experiences while conducting this phase<sup>2</sup>. As my journey continued I concluded that this is not possible. I am connected to the research and the thesis I have produced, as it has been part of my life for six years, therefore to try to withdraw myself and commit to being neutral is unrealistic and not achievable. Feminist research allows women's and midwives' voices to be heard and accepts the connection of the researcher with the research therefore supporting this approach. Feminist methodology cannot be independent of the ontology, epistemology, subjectivity, politics, ethics and social situation of the researcher (Ramazanoglu and Holland 2009), which I discuss in chapter 4.

I have integrated the voices of the women and the midwives throughout this thesis, especially in chapter 5 and 6, extracting the perceptions that women have at various stages through their childbirth journey. I have analysed the findings through a postmodern feminist technoscience lens, following identification of the themes from the first phase of the research, which followed an interpretive approach. My aim was to provide an honest account of the data received from both the women and midwives throughout the research process.

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<sup>2</sup> Discussed in chapter 3.

## **1.6 STRUCTURE OF THE THESIS**

In chapter 2 I investigate the background and literature related to this study. This chapter is divided into two parts. Part one discusses the background, which includes the current midwifery policy and the historical events that have influenced the role in society of the midwife. The second part critically reviews the literature available in relation to perceptions of the role of the midwife. I have included four tables in this section for easy reference of the research discussed. This section sets the scene for the rest of the thesis.

I discuss the journey I have taken to find a theoretical perspective in chapter 3, which will provide an honest and in depth insight of the midwife's role through perspectives of women and midwives. This chapter also includes the methodology for the first phase of this study, the findings of which I used to inform the second phase of the study. Ethical considerations and reflexivity are also included in the chapter.

Within chapter 4 I provide reasoning of how feminist research relates to the role of the midwife and interpretations of the midwife's role and childbirth within the media. In this chapter I provide an understanding of how feminist technoscience, specifically Haraway's (1991,1997) theories, can help us to understand perceptions of the role of the midwife. Methodology forms the rest of this chapter in relation to the second phase of the research study. Here I have also discussed epistemology and Haraway's concept of diffractions.

I discuss the initial exploration (first phase) of women's thoughts of what a midwife does in chapter 5. This investigated women's perceptions experiencing: different patterns of care, led by different health professionals; in different pregnancies, their first, second or third; and at different stages of their childbirth experience. The findings from this first phase are utilised to provide a framework for the second phase, which is discussed in chapter 6. In this chapter I have captured the views and thoughts of women and midwives, which has provided the opportunity to match their 'situated knowledges'.

In chapter 7 I discuss the findings in relation to current evidence, feminist and technoscience theories, anthropology and postmodernism. In chapter 8 I have provided a conclusion to this thesis, with implications for practice and future research.

## **1.7 CONCLUSION**

Throughout this thesis I refer to midwives, doctors and birth partners as s/he, as any of these roles can be women or men. I in no way wish to infer that any of these roles should be one gender or the other.

In this thesis I hope to have found a way of joining social studies, technoscience and feminism with understanding aspects of contemporary midwifery practice and to have given a platform for women's and midwives' voices to be heard.

## **CHAPTER 2**

# **PERCEPTIONS OF THE MIDWIFE'S ROLE: WHAT HAS INFLUENCED WOMEN'S AND MIDWIVES' KNOWLEDGE?**

### **2.1 INTRODUCTION**

This second chapter introduces background information including historical factors that have influenced the role of the midwife. It appraises the current literature relating to women's perceptions of a midwife's role and provides the supportive evidence for the study rationale. It illuminates influences upon the perceptions of women and midwives related to the role of the midwife.

At the outset I acknowledge my own personal and professional stance and the potential these have in influencing my understanding of the literature and subsequent research. I do not attempt to bracket my own views and experiences from the study. My own experiences and understanding of midwifery and technocratic medicalised birth, informed partly by my interpretation of the literature, have shaped my views over the past eighteen years, throughout my midwifery career. To allow immersion into the study it is important to acknowledge my own values and beliefs, which are discussed in more detail in chapter 4.

This current chapter is divided into two sections, the background and the literature review. The background includes definitions of a midwife's role and the historical role of a midwife. The literature review is broken into three parts. The first part discusses how midwives view their role, which includes how these are related to models of care or environments they practice in. The second part relates to how women perceive the midwife's role and the third part discusses partners' and fathers' views about the midwife's role. It is important to view the evidence from all three perspectives to see whether views are aligned, identify any differences and uncover supporting rationale for why such differences occur.

By the end of this chapter there will be a clear understanding of the background and literature relating to this study.

## **2.2 SECTION 1: BACKGROUND**

### **2.2.1 INTRODUCTION**

This section of the Chapter provides insight into the origins of the profession and the political issues surrounding midwifery. It will set the scene for the rest of this thesis and provide understanding of how midwifery has developed into its current state.

The first two parts of this section will contribute to understanding the terms used throughout this thesis relating to the role of the midwife; medicalisation of childbirth and technocratic birth. The rest of this section will provide an understanding of how women perceive their role, while understanding the influences that have occurred historically, which may have shaped their perceptions. It investigates current maternity policy, the historical role of the midwife, male influence on midwifery, medicalisation of birth and ways of knowing.

The art of moving forward is to understand where we have come from.

### **2.2.2 DEFINITION OF THE ROLE OF A MIDWIFE**

The definition of the role of a midwife varies from the perspective of the individuals or groups it has been written by. Because this exploration concerns women's understanding of the midwife's role, how it is described generally is an important consideration. Information required is generally sourced via the Internet through parenting sites, for example:

*"A midwife is a highly skilled, trained professional who provides advice and care for expectant mothers. A midwife organises and carries out tests and scans during the pregnancy to check mother and baby are healthy. She offers advice and support at this time when an array of changes are taking place for the mother - to both her body and her feelings.*

*Closer to the due date, when the baby is ready to be born, the midwife organises the birth itself and is on hand in case the mother goes into labour. From the onset of labour the midwife is present to assist and advise the course of the birth itself, from helping the mother through her contractions to the delivering of the baby. The midwife reassures and calms the mother, whilst also ensuring that things are going smoothly.*

*"Once the new baby has been born, the midwife will help the new mother to adjust. For example if she has difficulty in getting the baby to suckle, the midwife can advise and assist with her experience and knowledge. Further*

*support and guidance is provided for the mother by the midwife whilst she recovers from her birth”*  
([www.blurtit.com](http://www.blurtit.com)).

This definition emphasises the need for testing and technology in pregnancy and infers that there is continuity with the same midwife throughout her childbearing experience. It also focuses on abnormality rather than normality. Generally the emphasis is on the midwife supporting the mother to give birth and help her adjust to the changes she will experience. The information found can be extremely varied. Here is an answer from Yahoo.com, in response to a question asked by a woman in America, in relation to the midwives role:

*“A midwife can see you throughout your entire pregnancy and even deliver the baby, as long as there are no complications. In which case she would defer to the expertise of an OB, who is qualified to perform surgery. Otherwise, there’s not much difference...most midwives have to be qualified and officially trained to practice in hospitals, I’m guessing. There are those who aren’t licensed, but I doubt they could practice in a hospital/OB’s office without being so. Some will even deliver your baby at home if that’s what they specialize in. My old OB’s practice had several on staff and they pretty much did everything the doctor did except c-section (but did do episiotomy)”*  
([www.answers.yahoo.com](http://www.answers.yahoo.com)).

Women searching to find out what a midwife’s role is from around the world would come into contact with this kind of information. The role in this explanation is interpreted as under the control of the obstetrician (OB). It infers that it is unusual for the midwife to help the woman give birth to her baby; that the obstetrician delivers the baby. This can influence women’s views of the role around the world.

The National Childbirth Trust in the UK describe the role of the midwife on their website:

*“You can go directly to a midwife for antenatal care.... You do not need to see an obstetrician (a doctor who specialises in childbirth) while you are pregnant or giving birth...a midwife must be able to care for women throughout pregnancy, birth, and during the postnatal period too, as well as care for newborn babies. She must be able to detect problems and summon medical help if needed, and be trained in emergency procedures herself. She also has a role in health education and preparation for parenthood, such as teaching antenatal classes”*  
(NCT 2009:3).



This is an entirely different perspective of the role of the midwife; this shows the diversity of interpretations.

The International Confederation of Midwives (ICM), the World Health Organisation (WHO) and the International Federation of Gynaecology and Obstetrics (FIGO) definition is:

*“A midwife is a person who, having been regularly admitted to a midwifery educational program that is duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery.*

*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 infant. This care includes preventive measures, the promotion of normal birth, the detection of complications in mother and child, accessing of medical or other appropriate assistance and the carrying out of emergency measures. The midwife has an important task in health counselling and education, not only for the woman, but also within the family and community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.*

*A midwife may practice in any setting including in the home, the community, hospitals, clinics or health units”*

(ICM 2005:2).

This definition is inclusive of midwives from around the world, but it includes an educational requisite, which has caused some controversy. The intention by WHO, ICM and FIGO are to reduce child mortality by two-thirds and improve maternal mortality ratios by reducing them by three quarters by 2015<sup>3</sup>. It is estimated that approximately 529,000 women die in childbirth each year, 99% of these being in the developing world. One of the main tools for achieving these goals is to ensure midwives are licensed and skilled, therefore WHO are targeting traditional birth attendants (TBA) to become licensed (WHO 2005) through training provided by them.

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<sup>3</sup>This is part of the Safe Motherhood Campaign [www.safemotherhood.org](http://www.safemotherhood.org) In 1987 the Safe Motherhood Campaign was set up by WHO, supported by ICM, FIGO. At that time the number of women suffering maternal deaths worldwide was estimated to be at least 600,000 each year - with 99% of deaths occurring in the developing world.

This has caused concern between TBA's, also known as a traditional midwife (TMs), who are primary pregnancy and childbirth care providers. It is estimated that in 2006 40% of births were attended by a TBA (UNFPA 2007). They provide the majority of primary maternity care in developing countries. Traditional midwives usually learn their trade through apprenticeship, although some may be wholly self-taught. They are not certified or licensed. Some developing countries lack midwifery programmes of study and have very few hospitals or clinics to work from, but they still provide care to women in pregnancy and childbirth within the community they live in. Anthropologists, such as Jordan (1993) and Davis-Floyd (2005) view the training provided to TBA's as heavily influenced by the developed world. The 'authoritative knowledge' being evident in the training is that of modern obstetrics, therefore their indigenous skills are being ignored (Jordan 1993, Davis-Floyd 2005). The power of modernity, which provides the underlying belief that nature can be improved upon and provides a scientific/ technological framework through which childbearing and its management could be redefined (Murphy-Lawless 1998), is expressed within this context as authoritative knowledge over that of the TBA.

Barclay (2009) describes how TBAs work with hospital midwives to learn each others skills and swap working environments to appreciate the role each of them play. She found that friendships and respect for each other's knowledge developed. This is real partnership working and provides a level platform for both to learn. We have so much to learn from TBA's about behaviour in labour and natural rhythms, yet we seem to view modernity as authoritative. This eradicates natural, beautiful skills that cannot be reclaimed. This corresponds with the issue of Independent Midwifery in the U.K and indemnity insurance, a topic discussed in more detail in the section entitled 'institutional control' later on in this chapter.

There is a definition of the role of the midwife from the ICM, which the Nursing and Midwifery Council (NMC) and the Royal College of Midwives (RCM) refer to for the U.K. The ICM, NMC or RCM do not feel it is necessary to give a definition of a medical practitioner, so therefore I initially found it strange that FIGO felt it was necessary to align itself to a definition of a midwife. Obstetrics

is not midwifery practice, but the practice of obstetricians and gynaecologists. By defining the role they are making a definitive statement for the future, so it is seen as a standard definition, a piece of history unable to be changed. Haraway (1997) discusses this kind of historical perception as a way of control and power. Regulating midwifery from a non-midwifery organisation stance authorises how another profession practices. When looking at the 1902 Midwives Act and the compromises made for midwifery to become a profession, provides greater insight into why this has happened.<sup>4</sup>

### **2.2.3 MEDICALISATION OF BIRTH**

Medicalisation of birth is widely debated in many midwifery and feminist forums. It is a contentious issue within midwifery and is discussed throughout this thesis. It is therefore important to explore this issue to help understand the background information within this chapter.

According to Becker and Nachtignall (1992) medicalisation of childbirth can essentially be defined as a process that has resulted in childbirth being regarded as a medical event rather than a social one,<sup>5</sup> an event in which human experiences are redefined as medical problems. Medicalisation is considered the norm when the cultural environment professionals are working in is entrenched with interventions, so an inaccurate perception of what normal birth is becomes distorted. This thesis focuses on medicalisation of childbirth<sup>6</sup>. This combined with modernity (Murphy-Lawless 1988) and authoritative knowledge (Jordan 1997) leads to a technocratic model of birth becoming the norm. Davis-Floyd (1992) provides a useful contrast of a technocratic model of birth and a holistic model of birth, which reflects the values and beliefs between the two. Due to the increasing prevalence within the developed world of the technocratic model of birth becoming authoritative, the Maternity Care Working Party<sup>7</sup> (2007) felt it was necessary to define exactly what a normal birth was, by providing a consensus statement of normal birth, which has now been adopted by the NHS Information Centre. Health care providers can access the information to ensure

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<sup>4</sup> See section on Professionalisation of the Midwife, section 2.2.5.4.

<sup>5</sup> Concept of medicalisation originates in medical sociology.

<sup>6</sup> Varying approaches exist.

<sup>7</sup> Set up due to normal birth and normal delivery being interpreted differently within different cultures and institutions providing maternity care.

their interpretation of what is a normal birth correlates across the United Kingdom (U.K). Birth Choice UK (2007) show how the caesarean section rates have increased from 12% of births in 1992 to 23% of births in 2005, while the normal birth rates plunged from 60% in 1994 to 48% in 2005; this has not led to significant improvements to perinatal mortality (Kings Fund 2008). This suggests that technocratic birth models have led to this situation in the U.K.

The statistical analysis by Tew (1986) found that the shift of birth to hospital, led to increased obstetric intervention and did not make birth safer, but resulted in birth being more dangerous. She suggested that improvements in perinatal mortality were due to healthier mothers, rather than improved maternity care. She analysed the evidence from official statistics, national surveys and specific studies, finding that perinatal mortality was much higher when obstetric interventions were used, as in consultant hospitals, compared to in unattached general practitioner maternity units and at home where they are rarely used. The conclusion holds true even after allowance has been made for the higher pre-delivery risk status of hospital births as a result of the booking and transfer policies.

*“It holds even more strongly for births at high than at low predicted risk. It follows that the increased use of interventions, implied by increased hospitalisation, could not have been the cause of the decline in the national perinatal mortality rate over the last 50 years and analysis of results by different methods confirms that the latter would have declined more in the absence of the former”*

(Tew 1986: 659).

She found that improvements in public health contributed to a reduction in the perinatal mortality rate, rather than the reduction being a result of moving birth into hospital. She argues that infant mortality rates would have been four points lower, if birth had continued within the home and GP facilities.

She sums up her analysis:

*“The organisation of the maternity service stands indicted by the evidence. Despite the beliefs of those responsible, it has not promoted, and cannot promote, the objective of reducing perinatal mortality”.*

Tew (1986:659).

For years the medical profession refused to publish her evidence as they tried to protect the impression that hospital birth was safer; finally they published it in 1986. But, as we can see from the figures produced by the Maternity Working

Party (2007) above, intervention continues with a decline in the number of normal births. This demonstrates the evidence Tew provided has had little impact on changing views on the safety of birth, therefore the perception that intervention and hospital birth is safer continues. Davis-Floyd et al (2009) argue that technocratic birth models do not work; they have led to increasing intervention and caesarean section rates, which have led to unnecessary morbidity and increased mortality. They demonstrate that low intervention models of birth can demonstrate lower morbidity and equivalent or lower mortality rates, when compared.

Medicalisation of childbirth has had an avalanche effect on midwifery practice and is very evident within current practice, which is discussed below in current midwifery policy. How this situation has occurred is detailed in the *history of childbirth*, later in this chapter.

#### **2.2.4 CURRENT MIDWIFERY POLICY**

Midwifery care is predominantly performed in hospital and the community. Antenatal and postnatal care is based in the community for the majority of women, with the majority of births occurring in hospital.

Medicalisation of birth has increased dramatically, especially over the last twenty years, as discussed in the previous section. This is demonstrated in the caesarean section rate, which has increased from 12% to 24%, between 1990 to 2005 (Kings Fund 2008).

Many would argue that intervention of the normal physiological birth process is necessary to make birth safer (DHSS 1970, Friedman 1978, O'Driscoll and Meagher 1980). In reality the perinatal mortality rate has only fallen by 3% compared to a 100% rise in the caesarean section rate over a fifteen-year period<sup>8</sup> (Kings Fund 2008), indicating that the rise in intervention has had no effect on survival rates for babies in England. Medical intervention, including caesarean section can cause harm (NICE 2008). This is not always made clear to the women at the time of the intervention. The Kings Fund (2008) documents the harm associated with interventions, including caesarean section and epidural anaesthesia. This evidence will hopefully help to influence models of

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<sup>8</sup> Between 1990 to 2005

care used and environments for birth created in the future. The Cochrane review evaluating midwifery led care (Sandall et al 2008) included 11 trials, including 12,276 women. All authors evaluated methodological quality. The conclusions of this review were that women who had midwife-led models of care were less likely to experience: antenatal hospitalisation; the use of regional analgesia; episiotomy; instrumental delivery; were more likely to experience no intrapartum analgesia/ anaesthesia; experience spontaneous vaginal birth; feel in control during labour and childbirth; have attendance at birth by a known midwife; initiate breastfeeding; women who were randomised to receive midwife-led care were less likely to experience fetal loss before 24 weeks' gestation; their babies were more likely to have a shorter length of hospital stay; there were no statistically significant differences between groups for overall fetal loss/neonatal death or fetal loss/neonatal death of at least 24 weeks.

The authors concluded that:

*“All women should be offered midwife-led models of care and women should be encouraged to ask for this option”*  
(Sandall et al 2008:3).

The National Service Framework for Children (Department of Health 2005) set out the need for services to be more flexible and tailored to individual needs, with a focus on the disadvantaged and vulnerable. It also suggested that midwifery led models and environments should be available for women expected to experience a normal pregnancy and birth. 'Making it Better' (Department of Health 2007a) went a step further by discussing how midwifery led environments can give more choice and accessibility for women, without losing consultant led services. It discussed that services should be tailor made to include marginalised groups of women and their families; this then paved the way for a pioneering document.

Maternity Matters (Department of Health 2007b) is a positive development by the government to set out the way forward for maternity services, moving away from the ineffective medicalisation occurring on labour wards across the UK. It offered a national choice guarantee, which would be met by all maternity service providers by the end of 2009. This guarantee consisted of: choice of how to access care; choice of type of antenatal care; and choice of place of birth. The options for place of birth were: birth supported at home by a midwife;

birth supported by a midwife in a local midwifery facility such as a designated local midwifery unit or birth centre. The unit could be based in the community, or in a hospital. It added that these units promote a philosophy of normal and natural labour and childbirth. It also stated that women would be able to choose any available midwifery unit in England (Department of Health 2007).

Following the publication of the Healthcare Commission (2008) review of maternity services in England, where there was severe criticism by women of care received in their local maternity services, the Secretary of State announced additional funding for maternity services of £330 million over the next three years. The intention was that the extra funds should be used to support implementation of Maternity Matters and specifically to:

- Modernise options for place of birth, so the NHS can offer women a choice of home birth, birth in a midwifery unit or in a consultant-led unit.
- Improve accessibility of maternity services by, for example, opening more community midwifery locations such as Children's Centres.
- Increase workforce capacity within maternity and neonatal services and invest more in training for maternity staff and support workers.
- Promote the provision of locally accessible antenatal care and postnatal services.

This additional funding was included in PCT baseline allocations as part of the Comprehensive Spending Review settlement, which unfortunately was not ring fenced, so could be used for other services. Payment by Results (Department of Health 2008) also began, where a tariff was given for all care. This was paid by the PCT to the provider unit for maternity services for each individual. Unfortunately the payment for a caesarean section was much higher; therefore it gave more incentive to the provider to perform more caesarean sections and instrumental deliveries as their income increased. This is a perverse incentive as it increases the risk of complications and increases medicalisation of childbirth within the maternity services.

Recent government policy on the maternity services does not appear to have had a substantial impact on current services. This is due to the incentive to support medicalisation of childbirth by increasing the income for maternity

service providers for interventions, within the payments by results tariff set by the Department of Health (2008). Compounding this problem is the pressure on providers to meet waiting list targets for other NHS services. Unfortunately the money for maternity matters has not been ring fenced, so becomes absorbed by the institution into other services, which are viewed as a priority and increase income, due to the issues discussed. This has led to lack of action taken on meeting the demands of the Maternity Matters document. Instead many hospital trusts have chosen to move towards centralising services. This action has compounded the problem of increasing medicalised birth, as birth occurs on large centralised labour wards with a high proportion of medical staff present and interventions occurring as routine.

Maternity Matters (2007b) stated that choice has to be available by the end of 2009. All providers should now be offering alternative places to birth rather than a consultant unit; for many this has not been met. It will be interesting to see how the Department of Health deals with this situation. The way care is delivered could prove to have a significant impact on how women perceive the role of the midwife now and in the future.

## **2.2.5 THE HISTORICAL ROLE OF THE MIDWIFE.**

### **2.2.5.1 Traditional Birth.**

The role of the midwife has developed throughout the ages. Kitzinger (2005) describes birth traditionally, throughout the world, as a social process on female territory, where men are excluded. She describes skills such as movement, massage and powerful imagery as being handed down from grandmothers through mothers and daughters. She views this as keeping birth safe, creating social harmony and using spiritual forces through childbirth. Ancient sculptures and drawings of birth show the labouring woman having support from other women, usually kneeling in front of her or touching her face or shoulders. They usually project a very powerful supportive scene for the labouring woman, providing watchful waiting by her posse. The environment portrayed is usually the home. The women never appear fearful or anxious, despite the high rates of mortality and morbidity occurring at the time. The power of her labouring body is celebrated and respected by the women surrounding her.



Kitzinger (2005) describes the nativity scene as a complete contrast to the other interpretations around birth at that time. Images show no female support around Mary who appears isolated, with no other women in the scene. Joseph is distanced from her, with only the animals looking on. Jesus is placed away from his mother, not held by her. This image is celebrated at Christmas time, when most children's attention will be heightened during this period and accept the scene as a true interpretation of childbirth in the 'olden days'. This then perpetuates a whole new generation each year exposed to an unusual interpretation of childbirth history, believing this to be a frequent historical scene.

By the end of the eighteenth century, birth scenes were no longer celebrated within art and childbirth images began to migrate to obstetric text books (Witowski 1891). The woman's body became related to a machine, this became evident during the twin processes of the enlightenment period and industrialisation (Martin 2001). Birth is portrayed as technical and needing to be controlled and managed. It takes childbirth into a new realm, moving it away from nature and spirituality. Each part of the woman's body became labelled like a Haynes car manual; Wertz and Wertz (1977) describe how female midwives hands were replaced by male hands, using tools.

#### **2.2.5.2 Male Influence on Birth**

To understand why perceptions of the midwife's role need investigating it is essential to have an understanding of the history associated with birth. The role of the midwife has changed and developed through time.

#### **2.2.5.3 Male Midwives**

According to Arney (1992) male midwives appeared in the seventeenth century. These men tended to be called in by women attendants if there were problems with the birth. They were not doctors, but attended women in labour. They were known as 'barber surgeons' (Donnison 1988). The difference for the 'better educated man' was the licence granted to graduates in medicine by the Universities, which allowed them to practice as a 'physician' or 'doctor'. Incidentally this avenue was only opened to women in the 1870s (Blake 1990). Therefore our current day obstetricians emerged as a result of male midwives.

From the 1720s onwards men became increasingly common birth attendants, for normal as well as abnormal labours. This put them in direct competition with the midwife. Due to women having families and homes to maintain, they had less time and opportunity to attend women, so men were filling the void. 'Men of learning' also had a higher status than midwives irrespective of their skill and were being chosen as attendants by middle class women, rather than the midwife (Donnison 1988). The invention of the 'forceps' in 1720 (Radcliffe 1947) then accelerated the involvement of men at births, as they were viewed as having a higher status, this leading to a higher position in society than the midwife and viewed as having power (Hunt and Symonds 1996). The male members of the Chamberlain family, who invented the forceps, were instrumental in promoting the male barber surgeon as the care provider for women in childbirth. Hugh the elder Chamberlain translated Mauriceau's book called *Midwifery Book Matters* from French to English. He supported the view of physicians becoming involved in births, even those showing no sign of becoming complicated, he claimed that there were benefits of the involvement of a man-midwife. He was not frightened of threatening the livelihood of the midwife (Mander 2004). Midwives were reduced to only attending the poor, who were unable to pay for their services. In response, numbers of female midwives declined.

This led to the role of men in childbirth becoming known as a medical doctor and moved away from being termed a male midwife, metamorphosing into the obstetrician who is now a familiar part of maternity care in the world today. Mander (2004) describes how the existing balance of power in the birthing room has been overturned by men being able to exert their power directly over a relatively compliant female population by disrupting the normal status quo into a culture of medicalisation.

It was not until 1972 that men could apply for and be accepted into midwifery training. Imms (2005) describes his experience as a pioneer for this being an accepted norm. He was an instigator with Lord Dormund and Lord Owen at changing the law. They did this by upholding the Sex Discrimination Act of 1975, and by the dispensing of the legal ban on men practicing as midwives in

the Midwives Act (1951). This then allowed men to train as midwives. He describes both the nursing and midwifery profession as 'living in the dark ages' at the time, because its members were suspicious of men training for both of these professions. The change of men wanting to become midwives seemed to coincide with when men were present at births in hospital as the birth partner. This occurred in the early 1970s (Lewis 1991) instead of the female companion previously evident at homebirths. This was the first time they were able to see what the role of a midwife was and the value in supporting women giving birth. So, instead of trying to take over the role with medicalisation and control over childbirth and viewing the woman as needing to be 'rescued', which is a paternalistic, masculine power and control perspective, these men were able to understand the psychological and physical nature of birth and how they could support women through this normal process. Men therefore take on a feminist perspective to enable them to function successfully in this role; in sociological terms the role is associated with the gender (Kent 2000).

Through my personal experience over the past nineteen years of being a midwife I have observed female obstetricians and male midwives working within the maternity services. In traditional gender roles men are generally expected to be independent, aggressive, physical, ambitious, and able to control their emotions; women are generally expected to be passive, sensitive, emotional, nurturing, and supportive. Over time these traditional roles have mixed and crossed over between the two gender roles. These characteristics are also mixed with individual personalities. A female obstetrician may appear to relinquish her femininity to enable functionality in the role of a doctor, adopting masculine qualities to enable her to function as an obstetrician. In the same way, a man may relinquish their masculinity to function in the role of a midwife. In many respects the NHS functions in a paternalistic, masculine dominated power structure; therefore females may feel that they have to conform to survive or make change within the organisation. For example, a female obstetrician may adapt her behaviour to influence the masculine power structure to improve maternity services for women, working fluidly, if viewed from a postmodernist position (Mitchell 1996).

#### **2.2.5.4 Professionalisation of the Midwife**

It was not until 1902 that the Midwives Act became effective in England, 100 years later than some other countries, after a struggle by women and midwives (Donnison 1988). By this time many women had given up their support for women in childbirth as the medical doctor was now attending the majority of births, taking over the midwife's role in childbirth.

Following the commencement of structured midwifery training midwives gained professional status. The government also encouraged local authorities to establish a subsidised or wholly salaried midwifery service by employing them directly or through grant-aided voluntary organisations. In 1936 a landmark in the history of midwifery a further Midwives Act ensured that all local authorities employed a salaried whole-time midwife to provide a midwifery service free of charge or at a reduced cost. This then led to midwives being under the umbrella of the National Health Service, after 1945, therefore protecting their employment and ensuring they received a salary. With gaining professionalisation there was a compromise to be made; members of the new midwifery council could only be made up of midwives selected by the Royal College of Obstetricians and Gynaecologists ( RCOG), therefore giving the ultimate power and influence on decision making to the obstetricians.

#### **2.2.5.5 The Move from Home to Hospital Birth**

There was a move towards hospital birth, with a decline in home birth, particularly in the 1970s. There were high levels of maternal mortality in the 1930s, which started political and professional demands for safer childbirth, which gained momentum in the 1960s and 1970s, even though at this time maternal mortality rates were improving (Tew 1986)<sup>9</sup>. A report by the Cranbrook Committee supported this viewpoint: this recommended a 70% hospital confinement rate. Then in 1970 the Peel Report recommended 100% hospital confinement in the interests of safety (DHSS 1970). The Short Report in 1984 then compounded the problem for midwives as it gave continued support to the belief of 100% hospital birth rate being safer and supported the maximum use of technology (HMSO 1984). This was not supported by the evidence, which showed that births attended by midwives at home were safer than in hospital,

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<sup>9</sup> See earlier section on medicalisation of birth, section 2.2.3.

due to the perinatal mortality rate decreasing due to improvements in Public Health, not because of the move to hospital birth (Tew 1986). Women from the upper classes who had the services of a doctor and a private nursing home were more 'at risk' than those of the working class who had a home birth attended by a midwife, as the risk of infection was probably greater than poor standards of housing (Symonds and Hunt 1996).

#### **2.2.5.6 The Emergence of Technocratic Birth**

In 1980 O'Driscoll and Meagher published a package of care that consisted of many elements, including one to one care in labour. But, it also included their active management plan for labour, this stated that labour should not last longer than twelve hours and promoted the use of invasive interventions in labour to ensure labour lasted only within this time constriction, as they claimed it reduced the rate of operative deliveries. The study failed to measure psychological effects of intervention and longer-term physical and psychological wellbeing of women involved in this package of care (Thornton 1996). Despite these considerations it was adopted across the majority of maternity units in the UK. It is still much in evidence today. It is very much part of management plans by both midwives and obstetricians and is the main basis of the medical model relating to obstetrics. It seems that active management of labour is the cornerstone to good obstetric management of women in labour and unless new research proves it is detrimental to women it will continue to be used. Throughout my experience of practicing as a midwife I have worked collaboratively with some supportive obstetricians in regards to preserving and promoting normality in childbirth. However there are others who support the research by O'Driscoll and Meagher (1980).. The increasing familiarisation of hospital birth led to a dramatic increase in medical intervention and consequently reduced midwives autonomy, skill and activity in birth (Robinson 1989); this had resulted in technocratic birth.

Davis- Floyd (1992) gives a comparison between a technocratic birth model and a holistic birth model of birth in 'Birth as an American Rite of Passage', this is reproduced in figure 2.1 below. Technocratic birth can be related to the 'Fordism Model' (Walsh 2007a). It is described as a production line work ethic (Giddens 2001) in the hospital institution, which is mixed with elements of

'Taylorism'. This is described as hierarchical, detached, possesses a strong regulatory function and focussed on product outcome. Its values are with predictability, standardisation and efficiency (Dubois et al 2001). 'Doing' can be seen as a key behaviour in Fordist approaches to production according to Walsh (2007a), which is supported by Fahy (1998) who argues that 'doing' is a product of the modernist technorational scientific approach. This production line work model relies heavily on the value of counting time to ensure production is completed to time deadlines. Downe and Dykes (2009) discuss the impact that counting time has had on maternity care and how this is at the root of obsessive obstetric practices which aim to control the 'machines' to prevent them from failing to produce. Due to the continued usage and value placed on technocratic birth, Downe and Dykes (2009) conclude that its impact continues due to the following elements:

*" The global economy where the dominant ideology is consumerism, where illusions of certainty and control of life events are valued, and where time is money. Those who value the uncertain, liminal, 'becoming' aspects of pregnancy and childbirth will need to find persuasive arguments to counter the current hegemony of risk-averse, time-limited childbirth"*  
(Downe and Dykes 2009:80)<sup>10</sup>.

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<sup>10</sup> This aspect will be investigated in more detail in relation to the results of this study in chapter 7.

**Figure 2.1 Models of Childbirth**

<b>Technocratic model of birth</b>	<b>Holistic model of birth</b>
<p>Male perspective            Woman= object            Classifying, separate approach            Body= machine            Female body= defective machine            Pregnancy and birth inherently pathological</p> <p>Hospital= factory            Baby= product            Fetus is separate from mother            Best interests of mother and baby antagonistic</p> <p>Supremacy of technology            Institution= significant social unit            Action based on facts, measurements            Only technological knowledge is valued</p> <p>Labour= mechanical process            Time is important; adherence to time charts during labour is essential            Once labour begins, it should progress steadily. If it does not, intervention is necessary            Medical intervention necessary in all births            Environmental ambience is not relevant            Woman in bed hooked up to machines where frequent vaginal examinations by staff is appropriate            Labour pain is problematic and unacceptable            Analgesia/anaesthesia for pain during labour</p> <p>Birth= a service medicine owns and supplies to society            Obstetrician= supervisor/ manager/ skilled technician            The doctor/ midwife delivers the baby</p>	<p>Female perspective            Woman= subject            Holistic, integrated approach            Body= organism            Female body= healthy organism            Pregnancy and birth inherently healthy</p> <p>Home= nurturing environment            Mother/ baby inseparable unit            Baby and mother are one            Good for mother= good for baby</p> <p>Sufficiency of nature            Family= essential social unit            Action based on body/ intuition            Experiential and emotional knowledge is highly valued</p> <p>Labour= a flow of experience            Time is irrelevant; the flow of a woman's experience is important            Labour can stop and start, follow its own rhythms of speeding up or slowing</p> <p>Facilitation (food, positioning, support) is appropriate</p> <p>Labour pain is acceptable, normal            Mind/ body integration, labour support for pain</p> <p>Birth= an activity a woman does that brings new life            Midwife= skilled guide, responsibility is the mother's.            The mother births the baby</p>

(Davis- Floyd 1992:160-1)

### **2.2.5.7 Turning the Tide**

The Winterton Report (Department of Health 1992) acknowledged that encouraging all women to give birth in hospital could not be justified on grounds of safety. Following this, the Department of Health (1993) published *Changing Childbirth*, which became government policy. This aimed to give continuity, choice and control to childbearing women. This document had the potential for midwives to embrace it and reclaim their autonomy, but as Hunt (1996) describes, this was dependent on the midwives' willingness to resume their former responsibilities and accept accountability for their actions. Progress was also compounded by the government not producing any extra funds for the provision of this way of working. Midwives providing continuity of care to women within a midwifery team suffered 'burnout' as there were not enough midwives for the amount of women in their caseload (Sandall 1997). Other midwives did take advantage of this opportunity and developed case loading teams to provide the three 'Cs' (choice, continuity, control). This way of working was successful where caseloads were an appropriate size. These teams provided good outcomes and satisfaction for both woman and midwife (Flint et al 1989; Page et al 1999 and Sandall et al 2001). This was a real chance to change the tide; many midwives were enthused by this report. Currently in the UK there are very few case holding teams functioning due to lack of support within the maternity services. But there is a new start being led by midwifery education. Bournemouth University pioneered this approach within midwifery education and, with encouragement from the Nursing and Midwifery Council (NMC), many institutions have since followed suit. Student midwives within their midwifery practice experience have the opportunity to have a case load of women to whom they provide continuous care and support to, which has given the student midwives greater job satisfaction and the women have found greater satisfaction with their maternity care experience (Lewis 2009). This offers encouragement to offering continuity of maternity care to women. Two of the main reasons why the failure or lack of uptake of these schemes has occurred are due to the impact of technocratic birth on the midwife's role and institutional control.



## **2.2.6 THE IMPACT OF TECHNOCRATIC BIRTH ON THE MIDWIFE'S ROLE**

The medicalisation of childbirth led to a pattern of care that focused on an underpinning principle of ill health rather than focussing on the perspective of normality (Department of Health 1993, Green et al 1998), and where the philosophy of a normal birth was only seen in retrospect (Lavender and Walkinshaw 1998). However, there is now evidence that supports the efficacy and safety of providing care that has the foundation based in a normal model of care (Olsen 1997, Green et al 1998, Olsen and Jewell 2001). Despite this evidence, there is an indication of marked variation in the way maternity care is delivered to women (Foster and Gold 2002, Hall 2002). To compound this variation there is a lack of evidence that indicates how women (Garcia et al 1998) accept these differing models of care.

During the past ten years there has been a decline in the number of junior doctors, which has led to a review of the midwives' role, with units considering role expansion to encompass work previously done by the doctor, for example, ventouse practitioners. In an attempt to offer women a complete compliment of services, regardless of birth setting, midwives have adapted their roles in response to the reduction in availability of medical cover. Midwives have taken on roles such as ventouse practitioners, fetal blood sampling and amniocentesis (Lavender and Chapple 2002).

### **2.2.6.1 Institutional Control**

Technocratic birth was further enhanced by modernity (Murphy-Lawless 1998) and authoritative knowledge (Jordan 1997). These elements provided the medical model with the dominant discourse within hospital institutions, which has led to power and control by the medical model. This has been achieved by using control measures as a tool for control.

The pressure for all staff to comply with obstetrically led, clinical risk strategies in UK hospitals is immense (NHSLA 2009). Risk management grew from the industrial sector and aviation; it is a way of identifying what factors affected outcomes of accidents or disasters and what should have been done instead in

response to major disasters (Thompson and Owen 2005). Risk management and risk reduction in obstetrics is ultimately aimed at reducing cases of litigation taken out against the maternity services, which continues to be predominately those taken against the NHS as a whole (Cottee and Harding 2008).

NHSLA standards, previously called Clinical Negligence Scheme for Trusts (CNST) are standards, which have to be adhered to within hospitals and carry a financial reward if they are complied with, to help prevent cases of litigation occurring. Guidelines for all aspects of care are part of the standards. Depending on whom is involved with developing these, they can often restrict creativity and autonomy of midwives. Usually there are a significant number of doctors compared to midwives writing these guidelines or on guideline groups, therefore medicalisation is the dominant discourse. Midwives writing guidelines have to bend and negotiate their guidelines for them to be accepted by the group. Guidelines often favour medicalisation, as this can be more specific to time and measurement making it easier to audit, rather than the unpredictability of birth being spontaneous and physiological. A midwife's core responsibility is to be 'with woman', while protecting the values of physiological birth. This can be compromised, as midwives have to comply with the guidelines and rules of the institution or face working independently of the NHS. This control over childbirth can therefore prevent midwives from facilitating women's experience of physiological birth. This surveillance philosophy can suffocate normal midwifery practice. Risk and risk management have become the dominant discourses within maternity care. I would expect that the money generated from the financial reward obtained from meeting the NHSLA standards, I would expect to be put back into the maternity service to support innovation and creativity, but in my experience, it is unclear where the money is channelled.

Clinical directors of maternity services are predominantly obstetricians, there are very few midwives who are clinical directors across the UK. The head of midwifery at Cardiff is a deputy clinical director and a midwife at St Thomas' in London is a clinical director for their maternity services, with a separate head of midwifery. This post is pivotal to setting the direction of the maternity services within the trust. It is increasingly difficult for midwives to have their point of view heard or have the ability to change the service with a medicalised perspective

at the helm. Midwifery has to bow to the super power of abnormality and medicalisation. The best that seems to occur is negotiation and compromise to try to get some midwifery perspective threaded into the maternity services. This continuum of medicalised power then becomes viewed as normal midwifery care and may be supported by some managers and midwives, because it is easier to give in than fight against it (Lavender and Chapple 2002).

Currently the British Government are moving towards prohibiting any practitioners to practice if they do not hold indemnity insurance (DOH 2007). This cost to independent midwives is astronomic and would be totally unaffordable even if insurance companies would sell them insurance cover. This leaves midwives with no choice other than to be employed by the institution, which then restricts their ability to be able to provide woman centred care. All midwifery practice will be regulated to conform to the dominant patriarchal risk culture, sucking the lifeblood of creativity and autonomy out of midwifery, to ensure all midwifery practice is under the control of the dominant discourses of the institution. Lewis and Batey (1992) define autonomy within the confines of professional practice as:

*“ Freedom to make discretionary and binding decisions consistent with one’s scope of practice and freedom to act on those decisions”*  
Lewis and Batey (1992:15).

The midwife’s scope of practice has now become governed by the institution and national guidelines, which have become absorbed in technocratic birth practices, which the midwife now has to conform to.

### **2.2.7 HOLISTIC BIRTH**

The description of birth culture is traditionally about knowing birth intuitively, incorporating social and emotional needs. Before the seventeenth century birth knowledge was handed down through generations of women from observation and feelings, where birth was known about intuitively. Davis-Floyd (1992) identifies this as a holistic model of birth, through her anthropological findings. The body and mind are viewed as one self, as a whole, whereas the technocratic model divides the body into parts, separated from the mind and soul.

Kitzinger (2005) describes the spirituality of birth and how this is evident throughout time, especially within other non-western cultures through sculptures and carvings showing messages of spirituality being at the heart of physiological birth. Here she describes birth scenes in ancient drawings that have been salvaged:

*"Usually they show a mother giving birth in an upright position, attended by one or two women, supporting her from behind or kneeling in front---Dutch scenes show a comfortable and prosperous domestic setting, and focus on the social nature of the birth"*  
(Kitzinger 2005:24).

Hall and Taylor (2004) discuss spiritual birth as the ability to become wide open in the emotional and spiritual sense, as well as physically:

*"To be totally vulnerable, a woman requires a place of safety. It means she needs to feel safe within her physical environment"*  
(Hall and Taylor 2004:10).

Due to the wave of medicalisation that engulfed childbirth through history ensuring the birthplace was within a controlled environment, spirituality of birth has been suppressed within our westernised process of birth. To help understand why this happens, Jordan (1993) discusses authoritative knowledge and how it can be characterised through its dominance and authority:

*"To legitimize one way of knowing as authoritative devalues, often totally dismisses, all other ways of knowing. Those who espouse alternative knowledge systems tend to be seen as backward, ignorant or naïve troublemakers...the constitution of authoritative knowledge is an ongoing social process that both builds and reflects power relationships within a community of practice. It does so in such a way that all participants come to see the current social order as a natural order, i.e. as the way things (obviously) are"*  
(Jordan 1993:152).

Davis-Floyd (2001) suggests that the aim of giving holistic care may be too great a challenge in institutions that are technologically orientated due to the authoritative knowledge suppressing other ways of knowing. Therefore, women have less opportunity to experience spirituality and believe in the physiological nature of birth because this way of knowing is being suppressed by the authoritative knowledge of the institution and its organisational culture.

Jordan's (1997) study of birth in an American hospital found that: the woman and her partner are never spoken to directly by the doctor; the messages are

relayed through the midwife; the midwife has to wait for the doctor to make the decisions; the midwife implies that even if she did perform a vaginal examination the doctor would not consider her findings as a true interpretation and he would perform another anyway.

Jordan (1997) gives some excellent examples of the authoritative knowledge being held with the doctor. The midwife and woman are viewed as not having the knowledge to make any decisions. There appears to be a hierarchy here, where the doctor is at the top, the midwife is next, the woman and the partner at the bottom. The woman's knowledge about her own body is dismissed as invalid by the doctor. The medicalised discourse controls the relationships within the institution and therefore, has the authoritative knowledge.

Polanyi's (1963) theory explains how beliefs rather than evidence become a true fact and become authoritative knowledge. Polanyi argued that scientific knowledge is:

*"Steadfastly committed to established beliefs and dogmas within the scientific community. It is the social scientific community, not a rational scientific method, that is the determining condition of scientific knowledge"*  
(Polanyi 1963:375).

Downe and McCourt (2004) give a detailed exploration of the history of scientific thought and the limitations of applying theories of certainty viewed from a technocratic birth paradigm. Generally these results are viewed as authoritative knowledge and applied to the whole of the population when childbirth is about complexity and chaos and does not reflect all childbirth experiences. Beliefs, for example, that caesarean section is safer and has reduced perinatal mortality and morbidity, when it has not made any significant difference and has increased morbidity (Kings Fund 2008)<sup>11</sup> have become viewed as fact.

Evidence of how knowledge is constructed by midwives can be found in Hunter's (2008) work. She used poems written by ten American midwives to draw out three authoritative ways of knowing that guided their care given to women during childbirth. They were: self-knowledge from the belief system of the individual midwife; grounded knowledge from the midwife's personal lived

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<sup>11</sup> See section 2.2.4 Current midwifery policy

experience with childbirth; and informed knowledge from objective and scholarly sources. Their beliefs are constructed into fact, which forms their knowledge base and will be passed onto others.

### **2.2.8 CONCLUSION**

I have discussed in detail the current political position of maternity services and the definition of the midwife's role. The historical factors of midwifery and how it has been influenced by medicalisation and technocratic birth have given an insight into the factors affecting maternity services today. Traditional holistic factors and the dominance of authoritative knowledge from obstetric practices have been explored. My chosen definition of technocratic birth and holistic birth throughout this thesis is Davis- Floyd's (1992), discussed within this chapter.<sup>12</sup>

The information gained from this part of my thesis will assist understanding of how knowledge bases have been formed and how women's and midwives perceptions found in this study have been constructed. I will now discuss the second part of this chapter, where I have reviewed the literature.

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<sup>12</sup> See figure 2.1.

## **2.3 SECTION 2: LITERATURE REVIEW**

### **2.3.1 INTRODUCTION**

This review will provide a comprehensive overview of the literature available relating to perceptions of the role of the midwife. Gray (1997) discusses how this helps place the information into perspective. Problems with literature reviews are around the association with bias (Slavin 1995; Hutchinson 1993). A critique of the literature is required to ensure conclusions are not based on opinion, but on the data, as this could be interpreted as bias (Oxman et al 1994). This review is a comprehensive narrative synthesis. It provides a broad perspective on the evidence available and provides objective conclusions based upon the literature reviewed. This is an acceptable approach when conducting qualitative research (Green et al 2006).

The review is divided into three sections: how midwives view their role, how women view the midwife's role and how partners view the midwife's role. For easy reference, I have included the research in tables (figures 2.3.4.1, 2.3.4.2, 2.3.4.3 and 2.3.4.4), which includes: the findings; the methods used; strengths and weaknesses of each study and a critique in relation to the CASP tool. I have used the CASP tool (Public Health Resource Unit 2006) to add further clarity and credibility to my literature review. There are other appraisal tools, but CASP does examine individual studies critically, while also being user friendly. I acknowledge that there are limitations to using CASP as an appraisal tool, which I have taken into consideration when using it. Courtney and Mc Cutcheon (2010) discuss the importance of viewing a paper holistically, as many specific aspects of a study may not be identified using CASP. Walsh and Downe (2006) also suggest this, as they acknowledge that the theoretical perspective of a study may be overlooked. Glaser and Strauss (1967) argue that an appraisal tool will pre-empt and unduly influence emerging theory, stifling original insights discovered. Walsh and Downe (2006) argue that this detachment is unrealistic and may be perceived as dishonest.

I have included only research studies in my review. Initially I searched within a ten-year period between 1994-2004, as I wanted to view the midwives role within contemporary practice. Throughout performing my research studies and writing this thesis I have continued to do a similar search on a 6 monthly basis,

to see if there were any new studies. I also used forums and networks to find out current information through discussion. This was to ensure I included the most current information available in relation to perceptions of a midwife's role.

I used the principles of Robson (2002) to search for my literature: what is known about the topic; what is seen as problematic; the approaches that have been taken. I used the following databases to inform my review: Bandolier, Cochrane Library, DARE, HTA Database, NHS EED, MED, British Nursing Index, CINAHL, E-books, EMBASE, HMIC, MEDLINE, My Journals, PsycINFO, PubMed, MIDIRS initially at the beginning of the study, over a ten year period from 1994-2004, then through the life of this study and thesis. I searched using Boolean terms. I searched for 'midwife' and different synonyms relating to views, opinions, feelings and thoughts of women, midwives and partners in relation to the role of the midwife. This led me to 262 results. The majority of the studies (240) looked specifically at one particular area of midwifery practice relating to management of certain conditions, not midwifery practice in general, for example, diabetes and pre-eclampsia. As I was not looking at one particular area but views about the midwife's role in a general context, I excluded all studies that looked at research relating to management of particular conditions in relation to pregnancy and birth. There were fifteen studies left, these related to views of midwifery practice in a general context, including models of care, based on an international perspective. All of these studies were qualitative in design. The remaining studies I have divided into three distinct sections 'how midwives view their role', 'how women view the midwife's role', 'how partner's view the midwife's role'. Through the journey of performing my research and writing my thesis I have continued to add studies to this review, as discussed earlier. This has led to a total of twenty- eight studies being included. Investigation of the research already available is now provided. This will enable identification of any gaps in the current literature.



### **2.3.2 HOW MIDWIVES VIEW THE ROLE**

This part of the literature review concentrates on how midwives view their role. This will help give a clearer understanding of the presence of evidence, in relation to the role of the midwife. Within this part I have included a section relating to midwives working in different models of care, for ease of understanding the findings. There were eight studies relating to how midwives view their role (McCrea 1998, Lavender and Chapple 2002, Catterell et al. 2005, Lindberg et al. 2005, Larsson et al. 2007, Crozier et al. 2007, Houghton et al. 2008, Homer et al. 2008) and ten relating to midwives working in different models (Van der Hulst 1999, Downe and Mc Farlane 1999, Heres et al. 2000, Kirkham and Stapleton 2000, Ball et al. 2002, Mead and Kornbrot 2004, Hunter 2005a, Davis and Iredale 2006, Walsh 2007a, Health Care Commission 2008). In this section there were a total of eighteen studies.

Three of the studies (Lindberg et al. 2005, Larsson et al. 2007, Homer et al 2008) relating to how midwives view their role found evidence of midwives feeling inhibited to function as a midwife in the way they felt their role should be. The CASP tool (Public Health Resource Unit 2006) identified that a second method of data collection may have strengthened the studies. However, they did provide useful evidence to use as a foundation to enable investigation of how midwives think women perceive their role. In Australia, Homer et al (2008) found that women and midwives agreed on key elements that were required of a midwife, these were: being woman centred; providing safe and supportive care; working in collaboration with others when necessary. The midwives in the study felt that there was a lack of opportunity to practice across the full spectrum of maternity care. The barriers, which prevented this from happening, were due to the invisibility of midwifery in regulation and practice, the domination of medicine within the current institutionalised system of maternity care and workforce shortages. This study design included interviews from midwives, but not from women. The women's perspectives were drawn from surveys. The design of this study could have been improved by including interviews with the women; this would have added to the richness of the data collected. This study lacks real clarity on the women's views compared to those of the midwives, therefore provides only a superficial investigation of the issues.

Similar threads relating to how medicalisation prohibits midwifery practice were found in a study exploring how experienced midwives understand and experience their professional role in Sweden (Larsson et al 2007). Midwives felt their professional role in childbirth had decreased in favour of other professionals. The midwives felt they had a strong professional identity gained from their many years of experience (20-25 years), but felt their holistic skills, intuition and clinical experience have become less valued due to increased medical technology and organisational change. This study was based on midwives working in one hospital in Sweden and on four focus groups, in total 10 midwives. In depth interviews may have provided richer data. The focus groups provided a good baseline of information, but to strengthen this follow up interviews would have gained further insight into the midwives' views. A further study in Sweden (Lindberg et al 2005) investigating midwives' experiences of changes in their caring role and professional function in postpartum wards also resonates with the two studies above (Larsson 2007, Homer et al 2008). It found that midwives felt unable to perform their role successfully due to having time constraints and wanted to perform the whole spectrum of maternity care. An important discovery was that they perceived that they were no longer valued as the expert in childbirth. The study fell short of exploring how the midwives felt they could have provided maternity care to increase their job satisfaction. It included midwives who worked within postpartum wards at the hospital and not with midwives from a labour ward environment. Midwifery care could be interpreted differently depending on the current environment the midwife is practicing in, therefore perspectives from a midwife practicing on a labour ward may be different to a midwife working on a postnatal ward.

As with Lindberg et al's (2005) study, the next two studies relate to midwives working within postnatal care, so the findings may be different to midwives' views gained from experiences within an intrapartum perspective. This could lead to misinterpretation of midwives' views in general, as not all aspects of care are included. Cattrell et al (2005), in a study on postnatal care, aimed to investigate midwives' perceptions of the current role of the midwife; 65% (26) of the midwives invited attended the focus groups. Although this study is not related to birth it does show aspects of midwifery care, which are valued by midwives. These aspects were physical care was important, some felt it had

become routine rather than beneficial. Emotional support for women was valued. The majority felt able to identify early signs of postnatal depression. Debriefing following birth was important to women. Communication and support were a priority, but many felt unable to do this due to constraints on their time and viewed this as a barrier. Women needed good parent education preparation. Social expectations have changed with many demands on women in society, making parenting difficult. Midwives wanted to help by providing greater social support with an emphasis on public health. The majority viewed the media as creating unrealistic expectations of motherhood. They felt continuity of carer provided greater satisfaction for women and midwives, but felt frustrated when not able to provide this due to the organisation of care or time constraints. The role of the health care support worker in community is viewed as a support to the midwife, but it is important that they should not be used to take over aspects of the midwife's role.. The majority felt that a major barrier to providing postnatal care was performing non-midwifery duties.

This study complies with CASP criteria (Public Health Resource Unit 2006), but as previously discussed this study is based on midwives experiencing a postnatal care environment and not midwives working on a labour ward, so the findings may have been different if they were experiencing a consultant led labour ward.

In the UK, there is evidence to suggest that some midwives are concerned that their roles are extending in a direction which prevents them from doing the job, they were trained to do; supporting women in giving birth (Lavender et al 2001, 2002). Midwives suggested that while role extension can increase continuity of carer, it can devalue normal midwifery practice (Lavender et al 2002). This qualitative study found a different aspect not previously found in any of the other studies. Midwives suggested a dichotomy of roles, whereby there are 'low' and 'high' tech midwives (Lavender and Chapple 2002). This study did not investigate whether these 'low' and 'high' tech midwives practiced within a particular model of care or a particular area of practice. Houghton et al (2008) built on this information. This study used a qualitative interpretive approach, using questionnaires, non-participant observation and in-depth interviews. Women, their partners, midwives and obstetricians all participated in this study,

which provided a robust and multifaceted study. Across all of the groups, including midwives and obstetricians hospital birth was perceived as being a safer option for birth than home or a freestanding birth centre. Often midwives and obstetricians would bias the information they gave women in favour of hospital birth. This was compounded by their lack of faith in physiological birth, which influenced their approaches to birth place choices for women. Both midwives and obstetricians perceived medical interventions as part of the normal physiological birth process. This study provides an excellent insight into aspects of the midwife's role, within a robust and interesting methodological framework.

There were two ethnographic studies based on observation of the midwife's role in labour ward environments (Crozier et al 2007 and McCrea 1998). Crozier et al (2007) focused on observations of the midwife's role in relation to technology use. This study was based on two consultant maternity units in England emulating different cultures, both providing midwifery led and obstetric led care on both labour wards. It was identified that midwives practiced differently in the two units in relation to technology usage. One of the units tended to have a greater alliance with using traditional skills, for example, listening to the woman and palpating the abdomen. The other relied more on technology and its readings, regarding what was happening to the woman's body. Many of the midwives recognised technology as taking the place of traditional midwifery skills and could identify midwives that preferred to use machines and those who relied on traditional skills within the home environment. This resonates with the study conducted by Lindeberg et al (2005) in which midwives felt their traditional role was disappearing. It was recognised that midwives accepted policies and pump regimes without question, most of these decisions being made by obstetricians and anaesthetists. It was observed that midwives communicated with the machines through their settings and a surprising revelation that verbal communication with them was also observed. It was recognised that midwives would use CTG machines to allow them to care for two or three women in labour, using them as a 'babysitter'. Observation and conversations were the methods used. This study evaluated well against CASP (Public Health Resource Unit 2006), but it did fall down on two points. It would have strengthened the study if interviews had been performed to provide more

depth. Conversations with midwives were included, but greater clarity on some of the issues could have been gained from an in depth interview. In depth interviews with the women involved during these observations would have added the woman's perspective to the role of technology in relation to childbirth and the role of the midwife. This would have added further dimensions to this valuable piece of work. McCrea et al (1998) discusses the midwife's role in relation to pain relief. Observational data were collected from women and midwives on a labour ward in the maternity unit of a large teaching hospital in Northern Ireland; 11 midwives were observed and 15 women. McCrea et al (1998) identified three types of midwife in relation to providing pain relief. The 'cold professional' appeared to be influenced by the women's social class. Women identified as being in a higher social class were given information without asking for it and those perceived as being in a lower social class had to request information about pain relief. The 'cold professional' regarded pain relief as part of her job and spent much of her time checking machines and monitors, recording their results. McCrea et al (1998) describes this type of midwife as not appearing to work with the women, but 'did things' to them, caring for them in a 'coldly professional way'. The 'disorganised carer' appeared to provide care in a haphazard way, only giving information when requested to do so. She spent the majority of time out of the labour room, appearing to be nice to the women, but not providing care in a 'professional manner'. The 'warm professional' takes time to sit and talk to the women, explaining pain relief options. She provided emotional support to the women, regularly using 'touch' and speaking words of comfort. The women commented positively on the care they received, which was not observed for the 'cold professional' or the 'disorganised carer'. This is an interesting study in relation to the identification of three types midwives in relation to pain relief. The strengths of this study are that both women and midwives interactions were observed. The study in relation to the CASP (Public Health Resource Unit 2006) tool is positive, but falls down on only observation being used, as in depth interviews would have strengthened the research, as in Crozier et al's (2007) study. Only one site was used for the observations, therefore the findings may not be attributed to all maternity units.

The evidence in this section is valuable in terms of midwives' views of their role. Five of these studies were particularly useful in the contribution of knowledge to

midwives' views of their role. Three studies (Homer et al 2008, Houghton et al 2008 and Lavender and Chapple 2002) reflect the midwives' views and the perspectives of women, although Homer et al's (2008) evidence from women was limited, as it was based only on a survey. Crozier et al (2008) and McCrea (1998) add different perspectives about the midwife's role, Crozier et al (2008) in relation to technology and McCrea's (1998) identification of three types of midwife. The remaining eight were one-dimensional. It would have provided in depth data if there had have been an added dimension of interviews with women.

#### **2.3.2.1 Midwives working within different models of care**

While searching the literature it became evident that research into midwives' views of their role often encompassed a way of working; a model of care. This section relates to this work, which explores the literature concerning midwives practicing within different areas of midwifery practice. Included in this part of the review are ten studies.

The first two studies (McFarlane and Downe 1999, Hunter 2005a) show findings from midwives who appear to function differently depending on the environment they are working within. McFarlane and Downe (1999) asked midwives to assess their training needs. The findings showed two types of midwifery models. Midwives working in the hospital held a completely different concept of midwifery to those working in the community. This study was related to midwives' training needs and not specifically to their role, so although it has relevance it does not give any in depth information on the midwife's role. What is compelling is that the findings from this study do relate to a significant study by Hunter (2005a) who also describes two types of midwives. The first type work within a 'with woman' model, working in community based teams. These midwives worked in the version of midwifery practice, which gave an individualised holistic view and met individual women's needs:

*"It is informed by a belief in the normal physiology of childbirth, this ideology is officially sanctioned both professionally and academically, it is the midwifery which underpins policy documents and unit philosophies"*  
(Hunter 2005a: 1).

Midwives who are working in a 'with institution' model based within a hospital provided an institutional approach to birth. The focus was located within providing equitable care to large groups of women and their babies, to process them safely through the system, from hospital to home:

*"The focus is thus 'with women' rather than 'with woman'. This model is frequently informed by a medicalised approach to managing the chaotic and unpredictable process of childbirth"*  
(Hunter 2005a: 1).

Hunter's ethnographic study (2005a) found that those working in the community based teams were much more able to work in a 'with woman' manner congruent with their ideals regarding good practice, therefore, finding their work emotionally rewarding, especially when they could develop and sustain meaningful relationships with women, for example, if they were caseload carrying. Those working within the hospital experienced the needs of the institution as dominating their working day and their practice became 'with institution'. Emotional rewards were gained from 'getting through the work', for example, successfully completing tasks and not leaving them for the next shift. But, this did cause problems as it clashed with their midwifery ideals regarding good practice. This led to disillusionment and frustration. They either became resigned to this approach or were considering leaving midwifery.

Hunter's (2005a) study is an important one, which has led me to want to investigate these views in more depth. I am particularly interested in the 'institution' view, specifically the midwives working on a consultant led labour ward. The study drew on focus groups, observation and interviews which gave an in depth insight from a midwife's perspective about how they viewed their role. This study is strong in its validity as it draws on three different types of investigation brought together to provide this valuable insight.

The next three studies (Kirkham and Stapleton 2000, Ball et al 2002, Davis and Iredale 2006) have brought interesting findings to the debate, but were one dimensional in their data collection methods, which reduces the strength of the evidence collected. Parallels from the findings of Hunter (2005a) can be drawn to Ball et al (2002) who looked at why midwives leave midwifery. She found that midwives left due to an unwillingness to practice the type of midwifery

demanded of them by the modern NHS, despite their wish to continue as midwives. Many were dissatisfied with the requirements placed upon them to rotate through all shifts and around all areas of clinical practice, therefore finding it difficult to sustain relationships with colleagues and clients.

Davis and Iredale (2006) explored midwives' perceptions about their role and found that safe outcomes for mother and baby were paramount along with building trusting, supportive relationships. But, they also found midwives' autonomy is restricted by regulation and by the organisational systems of the NHS. The focus groups included midwives practicing within midwifery-led and consultant-led environments. Midwives expressed concern that medical staff interfered with normal childbirth and felt their role should be well defined, not to interfere in the care of women at low obstetric risk. They did however agree that if or when problems arose care should be handed over to an obstetrician. Kirkham and Stapleton (2000) found through interviewing midwives that they were constrained within the current culture of the NHS. They felt that this prevented their support needs being met and this then acted as an obstacle to develop midwifery practice.

The next two studies (Van der Hulst 1999, Mead and Kornbrot 2004) were based on a survey, which provides only superficial data. Using this method allows no depth to be created because each respondent will have different experiences, so investigation of their answer is not possible. There is therefore, an inability to probe the responses, which would be possible in an interview. In relation to CASP (Public Health Resource Unit 2006) the design of both of these studies could have been improved by including an additional method of data collection. A comparison of how an interview can be used effectively compared to a survey is demonstrated by Walsh and Baker (2004) where they discuss the work of Salmon (1999) who used interviews compared to Kettle (2003a; 2003b) who relied on surveys. Salmon's work brought a different perspective to the same subject of perineal suturing compared to Kettle's findings.

Mead and Kornbrot (2004) found that midwives working in a higher intervention unit perceived risk for the intrapartum care of women suitable for midwifery led



care differently to those in a low intervention unit. Midwives working in maternity units that had a higher level of intervention generally perceived intrapartum risks to be higher than midwives working in lower intervention units. However, midwives generally underestimated the ability of women to progress normally and overestimated the advantages of technological interventions, in particular epidural analgesia. The findings from this study are valuable but the findings were based on a survey, which as discussed above, gives a baseline of information but does not allow for any further depth. A study by Van der Hulst (1999) collected data from 150 midwives in the Netherlands via a questionnaire. The results showed differences in their behaviour according to the place where they provide the care for the labouring woman; at home or in the hospital. The most striking findings are that midwives are more relaxed whilst providing care at home, they take on a more informal approach and the interaction with the birthing woman is easier. As described before surveys and questionnaires have limitations, but still provide us with some valuable information.

The studies discussed in this section were restricted to midwives' views only; women's views were not sought. Midwives' views were the focus of their research questions and provide a robust platform to discovering midwives' perceptions of their role. Advancement to this evidence would be to reflect midwives' perceptions of their role with women's views of the midwife's role. This would allow for comparisons and possibly a totally different perspective may be found of the midwife's role. These explorations would add value to this knowledge base.

The survey from the Health Care Commission (2008) is based on women's views instead of midwives, but provides a valuable insight into what women expect from the midwife's role. It is based on a survey, therefore only provides us with superficial information. But, due to the large amount of women included it would have been impossible to perform interviews with all of these women. It may have been more beneficial to carry out a smaller number of interviews to gain richness of the data. The Healthcare Commission (2008) provided a countrywide survey across England, asking women about the care they had received within the maternity services. On average women with high satisfaction scores for their care in labour and birth had more indicators of

woman-centred care and fewer interventions. High satisfaction was associated with: shorter duration of labour; women receiving the pain relief they wanted; having a straightforward vaginal birth; being cared for by fewer midwives, having met them before; being spoken to in a way they could understand; being treated with kindness; having confidence and trust in the staff; and being given the information and explanations they needed. This survey covered all trusts across England, therefore it was a good sample size, but unfortunately surveys only provide us with some baseline information and further studies are needed to explore these issues further.

A further study (Heres et al 2000) looked at comparisons between two types of caregivers. The information was taken from a perinatal database in the Netherlands and therefore has limitations in its method, as it is only possible to gain the information that has been put in it, it is not possible to explore in more detail. This is described as a study, but in reality is an audit, as it is just extracting data from a database. I should therefore exclude it, but feel it does add a new dimension to the review and does contain information from a large sample size. A follow up study to explore the data further would have provided a deeper understanding of the reasons for the difference in length of labour. The study looked at the length of labour on women having a spontaneous labour and spontaneous birth by two groups of caregivers, a midwife and an obstetrician (Heres et al 2000). They found that labour was 5-6 hours longer for a primigravida and 3-4 hours longer for a multigravida woman cared for by an obstetrician than by a midwife. This seems to suggest that women felt more able to get through their labour quicker with the care from a midwife compared to an obstetrician, but fails to go into the reasons for this. There was nearly a 50% difference in numbers, 57,871 women in the midwives group and 31,999 women in the obstetrician group therefore there may be some bias towards the midwives group. This study does not comply with CASP (Public Health Resource Unit 2006), as the data is based on an audit and not qualitative research methods.

The next study (Walsh 2007a) has a robust methodology and provides a comprehensive view of the midwife's role and perceptions of women in relation to midwifery care in a Birth Centre. This study, along with Hunter (2005a),

provides the most robust methods within this literature review, which is identified in relation to CASP (Public Health Resource Unit). They are methodologically superior in comparison to the other studies included in this review. The study was revolutionary in showing the integral working between the staff and how this created job satisfaction. In Walsh's (2007a) ethnographic study of a Birth Centre the midwives felt able to practice autonomously and demonstrated social as well as clinical support to women. They also exhibited investment in social capital between themselves as a group, regularly covering shifts for each other and working flexibly to accommodate each person's home life. These factors helped to create good job satisfaction. This study was based on interviews of women and midwives. It also incorporated observation, making this a well-constructed study. The focus of the study was about Birth Centre care and had a different focus to women's perceptions of a midwife's role.

The evidence suggests that midwives working within a 'woman-centred' holistic type of model or possessing these values, (the majority situated away from the hospital) feel able to practice autonomously in a non-interventionist culture which provides good outcomes for the women and satisfaction for the midwives. It suggests that midwives working within a hospital environment feel their autonomy is restrained by the hospital culture, they have higher medical intervention rates and they feel compelled to "get through the work" in a conveyor belt sort of system, described as 'Fordism' (Giddens 2001). Walsh (2007a) describes how the Birth Centre philosophy has taken birth off the assembly line and discusses how 'Fordism' is evident in our hospital culture from the data collected. It is then interesting to see that within the hospital culture there are still differences in care with different caregivers. It appears that there are scales of autonomy and medical intervention levels depending on the environment and the caregiver.

There is a lack of evidence on how midwives think women view their role. The evidence in this section shows how midwives work within their role. Looking from different vantage points would provide a greater understanding.

### **2.3.3 HOW WOMEN PERCEIVE THE ROLE OF THE MIDWIFE**

In this section of the literature review there are twelve studies. There is very little known about how women feel about current midwifery roles. The limited evidence focuses on satisfaction with midwifery care or midwifery models. Within the U.K. there is evidence about satisfaction with a caseloading, holistic model of care (Page et al 1999, Flint et al 1989, Sandal et al 2001), but nothing specifically about the midwife's role. These caseloading models provided women with high levels of satisfaction of care, where the majority knew their carer throughout pregnancy, labour, birth and the postnatal period. These studies are valuable but are an evaluation of a model of care from the women's perspective, not necessarily about perceptions of the midwife's role. The methods used in these studies consisted of questionnaires in both the antenatal and postnatal period and also included interviews, which adds richness to the superficial nature of the questionnaires.

The next two studies (McCourt 2006, Walsh 2007a) used observation within their methodology. Walsh's (2007a) study used interviews too, which supported the evidence found from the observations. McCourt (2006) investigated communication in the U.K. between women and midwives in the antenatal period. Through an observational study she found differences with women receiving conventional care (different midwives through different parts of the care continuum delivering care to the same woman) and case loading care (the same or a small group of midwives delivering care throughout the care continuum to the same woman). The midwives delivering care conventionally used hierarchical and formal styles of communication. The case loading midwives delivered communication in a less hierarchical styles and a more conversational form, which was reflected in previous women's reports, as they felt this style offered them greater information, choice and control. This leads to the conclusion that organisation of care can influence the concept of choice in childbirth and increase women's satisfaction with their childbirth experience. This study included observing interviews between women and midwives in different settings, they had taken into consideration women's reports from a previous audit, but it would have added to the depth of the data if interviews with the women had also been part of the evidence. The women in Walsh's (2007a) birth centre study discussed how the midwife helped 'get them through'

labour, this seemed to be achieved by one to one support to all of the women he observed and interviewed. Walsh felt that the Birth Centre's robust indicator of effectiveness is one-to-one support, rather than the focus being about 'getting the women through the process' as quickly as possible; a culture evident in many hospital labour wards (Walsh 2007a). This is an important aspect but is related specifically to Birth Centre care. Walsh (2007a), as seen in the previous part of this literature review, performed interviews and observations of midwives, which gave this study a 360-degree view of a birth centre.

The next two studies (Homer et al 2008, Ortega Pineda et al 2001) lack depth when looking at women's views as they are based solely on survey data. If the survey had been supported by interviews or focus groups this would have provided a deeper exploration. They do however provide some interesting information. Within Homer et al's (2008) findings in Australia, which has been discussed within midwives' views of the role, women felt that there was a lack of a clear image of what midwifery is within society. Further understanding of what women meant by this and what the barriers to women are of interpreting a clearer image of the midwife's role require further data. It would have been of value to have also had data from in-depth interviews with the women, as they did with the midwives, instead of a survey. A Spanish study using a questionnaire (Ortega Pineda et al 2001) asked women what care provided by the midwife during normal labour were they most satisfied with. The results were: 'being treated with respect'; 'supporting immediate contact with the baby'; 'praising the women's efforts'. Care they were least satisfied with was: 'keeping the partner informed'; 'permitting participation in making decisions'; 'helping with initial breastfeed'. Because this information was based on a questionnaire it does not allow for any further investigation of the points raised; it would have been advantageous to explore why many of the women were not satisfied with their participation in decision making.

Two studies Lavender and Chapple (2002) and Houghton et al (2008) explored women's views in relation to their decisions regarding place of birth. Lavender and Chapple (2002) used a survey, which discovered that women felt that choosing to have a hospital birth was a safer option and were unaware of the

role of the midwife in relation to dealing with obstetric emergencies. This survey was supported by focus groups to explore midwives views<sup>13</sup>. The survey does not allow for deeper exploration, but this study benefits from being contrasted with midwives views through focus groups, which provides a different perspective to contribute to the findings. Within Houghton et al's (2008) study it was found that women felt midwives need technology to perform their role and the majority felt that hospital was a safer place to give birth to their baby<sup>14</sup>. This study combines different methods within its design, but did not compare women experiencing different models or birth environment's.

This gap is filled by Symon et al's (2007) study. Although it did not include data from women experiencing a homebirth it does provide a unique self - assessment of risk for collecting data from women. Symon et al (2007) compared outcomes for women who had given birth in two different environments, a consultant led unit and a midwife led unit. Postnatal questionnaires were used where the women rated their perception of risk in relation to their pregnancy, between 'none', 'low', 'moderate' or 'high' risk and asked for their opinions on the care they received. For those women who perceived themselves to be at risk levels of 'none' or 'low' they were included in the study. This included women who were transferred to a consultant led unit in labour from a midwife led unit. Data from these women were then compared in relation to the birth environment. Length of time spent in labour was shorter if the birth took place in a midwife led unit. Women in consultant led units were more likely to have used pharmacological analgesia. Almost all of the women intending to give birth in the midwife led unit experienced a normal vaginal birth. Women experienced more medical intervention if they were in a consultant led unit. This study implies that different philosophies operate within different types of birth environments. Women in the midwife led units reported a higher standard of care with midwives giving greater help and encouragement regarding their comfort and they felt more involved with decision-making. This study was performed across 9 different units (6 midwife led and 3 consultant led); it contains one type of method. It is an unusual study in relation to the women determining their own risk factor, interventions and progress in labour. It

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<sup>13</sup> Discussed in 'views of midwives' in previous section of this literature review.

<sup>14</sup> This study is also discussed in 'views of midwives' earlier in this literature review.

is not a particularly sophisticated measure, but does give us a different perspective on interpretation of risk and provides us with a consumer led perspective. In relation to CASP, this study only uses a questionnaire as a method, but is strengthened by the different sites included for data collection. Interviews would have strengthened the data to provide more depth in relation to women's comments about their experiences.

This study by Seibold et al (1999) along with Walsh (2007a), Houghton et al (2008) and Eliasson et al (2008), which follows later, provide the most robust evidence in this review. Seibold et al (1999) in Australia collected data via interviews pre and post birth, plus observations in labour to find out strategies hospital midwives used in assisting women to manage pain in labour and support they offer in all aspects of the birth process. Her findings revealed all of the women wanted a birth with minimal intervention, but viewed safety as an overriding consideration when considering place of birth, which reflects evidence from Lavender and Chapple (2002) and Houghton et al (2008). During labour women relied on the midwife to oversee and direct care. Trust in the midwife to care for her was established as a result of prior experience, or during antenatal care. Factors inhibiting full partnership between the woman and the midwife included: finding alternative pain methods; staffing levels, which inhibited the amount of time the woman felt she needed with the midwife; lack of emphasis on evidence based care and environmental constraints such as the room set up. Within this study there were 5 women and 5 midwives, initially this appears to be a small number, but because of the different research methodology utilised, this increases its richness, providing greater depth.

A study using a Hermeneutic<sup>15</sup> approach in Sweden with 67 primigravida women (Eliasson et al 2008) found that nearly half (32) of the women described the midwife during labour and birth as uncaring. They felt that they had not been cared for during the birth. There were two distinct categories: 'the midwife's humiliating behaviour', where the midwife ignored the mother or the mother held the midwife in contempt; 'the midwife's humiliating actions', where the mother felt the midwife disbelieved her, treated her body in a careless

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<sup>15</sup> The Hermeneutic approach focuses on the significance that an aspect of reality takes on for the people under study. Hermeneutics focuses on defining shared linguistic meaning for a representation or symbol (Longworth and Kingdon 2010).

manner or where the mother felt the midwife put blame on her. Women felt they had handed themselves over to the midwife who then treated her carelessly, with no dignity. The author concluded that a woman's confidence could be violated when midwives abandon women in labour, do not take them seriously or do not approach them with respect and a sense of responsibility. She states:

*"Midwives bear responsibility for the memories that mothers will have for the birth of their child"*  
(Eliasson et al 2008: 510).

This study is based on women having a hospital birth, a comparison to women birthing in different environments would have been advantageous, but taken much longer to perform. This study does provide us with important information in relation to women's views of the midwife's role and complies with CASP (Public Health Resource Unit 2006) criteria.

There is little evidence on women's perceptions of the midwife's role. The evidence that is available concludes that women gain better satisfaction when they have continuity of care. They want a midwife to be with them through their childbirth experience, with one to one care creating a positive difference to their experience. There also appears to be a perception of hospital birth being safer than any other environment and a hint that technology is seen as important in maternity care. The majority of these studies are investigating one specific model or a care environment. There is limited evidence comparing views of women receiving care led by different professionals and also comparing women's views who have had different experiences of maternity services.

#### **2.3.4 PARTNER'S PERCEPTIONS OF THE MIDWIFE'S ROLE**

This part of the literature review looks at the perceptions of partners in relation to the role of the midwife. This perspective is important as they are often with women throughout their childbirth experiences and may influence their perceptions. Waldenstrom (1999) used a randomised control trial to compare partners' experiences of birth centre care and standard care (consultant led) across seven maternity units in Stockholm. Partners in the birth centre group assessed care as a more positive experience than those experiencing standard care. Attitudes by midwives was assessed as being more positive, the partners feeling they were treated with greater respect and felt the midwife was more



supportive than those experiencing standard care. This study used both quantitative and qualitative methods, consisting of a randomised control trial of 1143 partners and followed with two questionnaires, one assessed demographic information and the other based on their birth experiences. The response rate was 99% in the birth centre group and 94% in the standard care group. This study would have benefited by including interviews to explore the findings of the questionnaire further. The disadvantages of the randomised control trial is that women and their partners are unable to choose their birth place environment, which immediately forces them to relinquish control over this aspect of their childbirth experience. CASP is only used to evaluate qualitative data, therefore only the questionnaire can be considered within its assessment. This study only uses one method of qualitative research, therefore reduces the depth that may have been accessed by using a contributory qualitative method.

Singh and Newburn (2003) explored what men think of midwives. All partners were presumed as being men in this study. It was based on a randomly selected sample of men completing a questionnaire at 34 weeks gestation of the woman's pregnancy and a further questionnaire completed six months later. 817 men replied to the first questionnaire, response rate of 37% and 463 replied to the second, response rate of 57%. The findings showed that midwives were perceived as providing information in a way that they could understand and were willing to listen to how they were feeling. They believed that midwives encouraged them to ask questions 'most of the time'. One in five did not feel midwives encouraged them to ask questions and 1 in 6 felt that midwives were not willing to listen if they wanted to talk. One third felt midwives ignored them, talking mainly to their partner. 7% perceived that midwives avoided making eye contact with them. Midwives' communication skills were rated more highly than GPs and hospital doctors. Men were less satisfied with the way midwives communicated with them after the baby was born. Men visited by a midwife in their own homes tended to be more positive about midwifery care. This study did not distinguish the type of care that was received, midwifery led or consultant led and did not distinguish between birth environments, consultant led labour ward, alongside midwifery led unit, home or free standing birth

centre. Only questionnaires were used, benefit would have been gained by including interviews to establish greater clarity around the findings.

Longworth and Kingdon (2010) explored what fathers in the birth room expect and experience using a Heideggerian phenomenological approach. This consisted of in-depth interviews performed, one in the antenatal period and one in the postnatal period. The sample consisted of 11 expectant fathers. This study appeared to recognise the birth partner as the father, implying that they would be male. It appeared evident that prior to their first experience of birth they had faith in the health care professionals. The extent of communication with the midwife, themselves and their partner or other health care professional made a significant difference to the control and involvement felt by the fathers at the birth. This contributed to either a positive or negative experience of the birth. They judged themselves to be on the periphery of events during labour. A unique and interesting factor in this study relates to disembodiment fathers felt from the pregnancy which was evident in the antenatal interviews. It was not until the baby was born when fathers connected with the fact that they had 'become a father'. They tended to use technical language when talking about the birth experience, implying that this helped them to maintain a disconnection from the process. Personalisation of the baby only became apparent in the postnatal interviews and the use of the technical language was significantly reduced. Another interesting aspect is that the fathers discussed the role of the midwife as being linked to normality and only talked about the inclusion of doctors in relation to abnormality. They appeared to have great faith in the midwives and viewed the intrusion of doctors with ambiguity. The study does not distinguish between models of care or birth environments. The method provides a valuable exploration and allows for breadth and depth to be achieved of these fathers experiences.

### **2.3.5 CONCLUSION**

This review of the literature gives some valuable insights into how women, midwives and partners view the role of a midwife. Many of the studies discussed report only one dimension, from either the woman's, midwife's or partner's viewpoint. Alternatively, the perceptions of the midwife's role are found within studies investigating a model or aspect of care. Hunter (2005a), Walsh (2007a) and Houghton et al. (2008) provide important and valuable evidence in relation to perceptions of a midwife's role. Crozier et al. (2008) and Symon et al (2007) provide supplementary evidence that puts a different stance into the pool of literature. However, none of the studies explore both women's and midwives' perceptions specifically about the midwife's role simultaneously.

This review revealed that from a midwife's perspective the midwife's role can be perceived differently depending on the model of care or environment the midwife is working within. Midwives can be identified as practicing differently to their peers, even within the same working environment. Midwives feel their role is extending in a direction away from their traditional values. The use of technology by midwives varies depending on reliance of traditional skills within different cultures. There was an expectation by women that midwives needed technology to function with their role. Women and partners experiencing a midwifery led environment appear to perceive improved experiences and women experienced better outcomes, including lower medical intervention rates. Interestingly women who have not experienced this model or birth environment perceive hospital birth to be a safer option. A midwifery caseloading model of care provides high levels of satisfaction among women who have experienced it and improved birth outcomes, compared to those experiencing traditional maternity care. Fathers feel on the periphery in the birth room and value direct communication with them from midwives, which they felt improves experiences. The disconnection fathers feel from the baby until after the birth is an interesting notion.

The majority of the studies comply with CASP (Public Health Resource Unit 2006) criteria, but stumble on the research design by not incorporating more than one method (Van der Hulst 1999, Ortega Pineda et al. 2001, Ball et al. 2002, Singh and Newburn 2003, Mead and Kornbrot 2004, Davis and Iredale

2006, Healthcare Commission 2008, Homer et al. 2008), which weakens their stature<sup>16</sup>. Heres et al's (2000) study was the weakest in relation to CASP (Public Health Resource Unit 2006) as it relied on audit evidence. Another shortcoming was using surveys and not investigating the findings from the survey further to provide a deeper exploration (Homer et al 2008, Healthcare Commission 2008, Mead and Kornbrot 2004, Singh and Newburn 2003, Ortega Pineda et al 2001, Downe and MacFarlane 1999, Van der Hulst 1999) this weakened their rating in relation to CASP (Public Health Resource Unit 2006). Some of the studies did compare different models or environments, but some investigated just one. In some studies, for example, Walsh (2007a) only one environment was investigated, but this was the intention of the researcher to explore this environment from different angles, therefore an in depth study using different research methods within the design was provided. This robust study of this environment can be compared to findings of studies of other environments; therefore only focusing on one is not necessarily a disadvantage. Houghton (2008), Walsh (2007a) and Hunter (2005a) are the strongest studies in relation to CASP (Public Health Resource Unit 2006).

This literature review provides evidence that there is merit in an in depth study being performed on perceptions of the midwife's role, as there still appears to be a gap in the evidence. All of the studies in this literature review are focused on a different aspect, but some of the findings relate to perceptions of the midwife's role. A study purely based on perceptions of the role would add stronger evidence to the knowledge base.

Tables 2.3.4.1, 2.3.4.2, 2.3.4.3 and 2.3.4.4 below, provide a summary of the research findings from the literature review in the form of tables, for easy reference.

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<sup>16</sup> See tables provided in conclusion, Tables 2.3.4.1, 2.3.4.2, 2.3.4.3 and 2.3.4.4

## Midwives' Views of Their Role

Main Findings	Methodology	Strengths and Weaknesses	CASP
<p>Midwives felt lack of opportunity to practice across the full spectrum of maternity care. Barriers to this were:</p> <ul style="list-style-type: none"> <li>Low visibility of midwifery in regulation and practice.</li> <li>Dominance in medicine within current institutionalised system</li> <li>Workforce shortages</li> </ul> <p>Women and midwives thought key elements of a midwife were:</p> <ul style="list-style-type: none"> <li>Being woman centred</li> <li>Providing safe supportive care</li> <li>Working in collaboration with others when necessary.</li> </ul>	<p>Data collected from surveys with women and interviews with midwives. One woman and midwife representing each state and territory in Australia (8).</p>	<p>Included interviews from midwives, but none from women. Women's views were collected. From surveys, therefore, lacks clarity of women's views compared to midwives'.</p>	<p>Complies, except on research design where interviews with the women may have added richness to the data collected.</p>
<p>Midwives and obstetricians:</p> <ul style="list-style-type: none"> <li>Perceive hospital birth as a safer option for birth than home or freestanding birth centre.</li> <li>Often bias information in favour of hospital birth.</li> <li>Lack faith in physiological birth process.</li> <li>Medical intervention perceived as part of the normal physiological birth process.</li> </ul>	<p>Triangulation of qualitative methods at 1 maternity unit.</p> <p>46 women completed booking questionnaire, 44 were observed.</p> <p>30 women completed a questionnaire at 34 wks gestation and all participated in an interview. Postal questionnaire completed by 30 women and participated in interview.</p> <p>32 partners completed questionnaire, 28 were observed. 20 partners completed a questionnaire at 34 wks gestation, 20 also being interviewed. 19 partners completed a postal questionnaire.</p>	<p>The triangulation of methods provides a robust framework. The inclusion of different participants, including women, partners, midwives, obstetricians and GPs provides a pivotal vantage point of women's views and the influences that lead to their choice of place of birth.</p> <p>This study provides a valuable contribution to views on the role of the midwife.</p>	<p>Weakened on 1 point- Only 1 maternity unit was included. The methodology used results in a comprehensive and robust study.</p>

	12 midwives, 9 senior obstetricians and 15 GPs were interviewed.		
<p>Midwives practiced differently in the two units in relation to technology usage:</p> <ul style="list-style-type: none"> <li>-One had greater reliance on traditional skills.</li> <li>- Other relied on technology.</li> </ul> <p>Midwives recognised technology changing the place of traditional midwifery skills and could identify midwives that preferred to use machines and those who relied on traditional skills, particularly in the home.</p> <p>Midwives accepted policies and pump regimes without question, most of these decisions were made by obstetricians and anaesthetists.</p> <p>Midwives communicated with the machines through their settings and verbal communication was also observed.</p>	<p>Ethnographic study consisting of observation in 2 maternity units. 16 midwives participated- 6 in one unit and ten in the other.</p>	<p>Provides interesting observations of midwives' interactions with technology. Conversations with midwives were included, but in depth interviews would have added greater clarity. Interviews with women would also have added a different perspective in relation to technology and its role in childbirth and as part of the midwife's role. This study provides valuable information.</p>	<p>Changes to the design may have improved the depth of data collected:</p> <ul style="list-style-type: none"> <li>-Mixture of methods would have provided greater clarity</li> <li>-Including in depth interviews with the women involved in the study would have given a different perspective.</li> </ul>
<p>Midwives felt their handcraft skills and practical experience have become less valued due to increased medical technology and organisational change.</p>	<p>4 focus groups. Total of 20 participants</p>	<p>Based on 4 focus groups. Follow up in depth interviews may have provided more depth.</p>	<p>Complies except groups were taken from only one site, therefore findings may only be particular with that site. Only one method was used, mixed methods may have added more definition to the findings.</p>

<p>Midwives felt unable to perform their role successfully due to time constraints and wished to have responsibility for childbirth in its entirety. It no longer valued as the expert in childbirth.</p>	<p>4 focus groups. Total of 21 midwives experiencing midwifery practice on maternity wards within northern Sweden at 2 sites.</p>	<p>Included only midwives working on the postnatal ward, not involved with birth.</p>	<p>Only one method was used, a mix of methods may have given a pivotal perspective.</p>
<p>Aspects of care valued by midwives are: Physical care, but had become routine rather than beneficial Emotional support Debriefing women following birth, but it unable to do this due to time constraints. Good parent education preparation. Wanted to help women by providing greater social support with an emphasis on public health. Viewed the media as creating unrealistic expectations of motherhood. It continuity of carer provided greater satisfaction for women and midwives, but felt unable to provide this due to organisational restraints. Viewed healthcare support worker as a support in the community to the midwife.</p>	<p>4 Focus groups. Total of 26 midwives attended experiencing midwifery practice on the postnatal ward.</p>	<p>Included only midwives working on the postnatal ward, not involved with birth.</p>	<p>Further clarity of findings may have been gained by using interviews as another dimension regarding methods.</p>

<p>Midwives felt their role was extending in a direction preventing them doing the job they were trained to do - supporting women in giving birth. Midwives suggested that there were low and high tech midwives.</p>	<p>Survey of pregnant women across 12 maternity units in England, which offered different birth settings. 15 focus groups at 14 maternity units in England offering different birth settings, attended by 120 midwives and 6 student midwives.</p>	<p>Valuable study, as this also explored women's views. Only touched on midwives views of their role. Did not investigate whether these low and high tech midwives practiced within a particular model of care or area of practice</p>	<p>Complies, but further depth could have been gained from interviews with a sample of the women and midwives involved in the survey and focus groups.</p>
<p>3 types of midwives were identified in relation to their role in providing pain relief: 'Cold professional' 'Disorganised carer' 'Warm professional'</p>	<p>Ethnographic study consisting of observation in 1 maternity unit. 11 midwives and 15 women participated</p>	<p>Its strengths lie in the identification of 3 types of midwives. In depth interviews would have provided greater depth in relation to women and midwives perspectives.</p>	<p>Weakened on 2 points - mixture of methods would have provided greater clarity. Only one site was used, findings might only be attributable to this site, but could be a support for the same findings found in other research.</p>



## Midwives Working in Different Models of Care

Findings	Methodology	Strengths and Weaknesses	CASP
<p>Women's satisfaction on care received from maternity services.</p> <ul style="list-style-type: none"> <li>·High satisfaction associated with:</li> <li>·Shorter duration of labour.</li> <li>·Receiving the pain relief they wanted</li> <li>· A straightforward vaginal birth</li> <li>·Cared for by fewer midwives, who they have met before.</li> <li>·Spoken to in a way they could understand</li> <li>·Treated with kindness</li> <li>·Confidence and trust in staff</li> <li>·Given information and explanations they needed</li> </ul>	<p>26,325 women responded to survey from 149 acute hospital trusts and 2 primary care trusts in England</p>	<p>Good sample size but based on a survey- therefore only a baseline view of the issues.</p>	<p>Extensive sample size. Mixed methods would have added greater clarity to the findings.</p>
<p>Ethnographic study of a Birth Centre.</p> <p>Midwives felt able to practice autonomously.</p> <p>Midwife's demonstrated social as well as clinical support to women.</p> <p>Demonstrated social capital between themselves as a group.</p> <p>Had good job satisfaction</p>	<p>Observation of women and midwives' interactions (20 visits) and interviews with both women (30, 3 months postnatal period) and staff (15) in a standalone birth centre.</p>	<p>Good methodology- interviews with women and midwives plus observation. Based on Birth Centre environment only.</p>	<p>Complies. Study design gives a 360-degree perspective of the subject studied. Based on one site, therefore findings may only be applicable to this site, which the researcher acknowledges.</p>
<p>Explored midwives perceptions of their role.</p> <p>Focus groups included midwives working in midwifery led and consultant led environments.</p> <p>Felt safe outcomes for mother and baby were paramount along with building trusting supportive relationships.</p> <p>Concerned medical staff interfere with normal childbirth</p>	<p>7 focus groups. 48 midwives from maternity units in mid and south Wales.</p>	<p>Valuable study in terms of midwives views, although follow up interviews would have been useful to explore in more depth.</p> <p>Did not look at women's views of the role.</p>	<p>A good sample size was generated. Only one type of method was used, the addition of other methods may have provided increased the richness of the data.</p>

<p>Similar to Downe and McFarlane (1999). Description of midwives working in community as working in a 'with woman' model of care and those in the hospital as 'working with institution'. The 'with institution' model was based on a medical approach to childbirth- managing the process. The 'with woman' model was based on individual woman's needs and a holistic view.</p> <p>The 'with woman' model matched the ideal role many of them believed their role to be.</p> <p>Therefore, those working in this way had increased job satisfaction.</p>	<p>4 focus groups, separated by location and setting of midwifery practice (hospital or community). Observational data of 6 working in a community setting and 6 hospital based midwives.</p>	<p>Valuable piece of work in terms of the findings, as this gives an exceptional overview of how working in different environments and models can change how care is delivered.</p> <p>Was specifically about how midwives viewed their role. It did not include women's perceptions of the midwife's role.</p>	<p>Mixed methods of data collection provide depth to the subject. The study was based on one site, therefore may only be applicable to this geographical area.</p>
<p>On higher levels of intervention environments midwives perceived risk as higher than those working in low intervention units.</p> <p>Those in higher interventionist units overestimated the value of technological interventions and underestimated women's ability to progress normally.</p>	<p>A survey of midwives' views (120) in 11 maternity units.</p>	<p>The findings are valuable but were based on a survey, therefore were only a baseline view.</p>	<p>Further investigation through other methods would have been useful to investigate the findings further.</p>
<p>Based on reasons of why midwives leave the profession.</p> <p>Reasons were:</p> <p>Unwillingness to continue practicing the type of midwifery demanded of them.</p> <p>Dissatisfied with requirements to rotate through all shifts and areas of practice- felt unable to sustain relationships with women and colleagues.</p>	<p>4 focus groups consisting of 6-10 midwives in each group.</p>	<p>Looked specifically at why midwives leave, not on how they perceived their role.</p>	<p>Complies. Addition of other methods within the design may have given more information regarding some of the findings.</p>

Midwives felt constrained within current culture of the NHS, which inhibited them to have support needs met and acted as an obstacle to progress in developing midwifery practice.	Interviews with 168 midwives at 6 different sites in England.	Did not look at women's views of the role.	Complies with CASP, another method may have added richness to the data.
Looked at length of labour of women having spontaneous labour and birth by 2 groups of care givers- obstetrician and midwife. Labour was 5-6hrs longer for primigravid women and 3-4hrs longer for multigravid women if cared for by an obstetrician.	57,871 women receiving care from midwives. 31,999 women receiving care from obstetricians. Descriptive study comparing the circadian pattern of the hour of birth.	There were more women in the midwives group; therefore there may have been some bias. The study did not investigate the reasons for the findings	This study did not contain any qualitative data and therefore cannot be measured against this tool.
Midwives working in hospital held completely different concept of midwifery to those working in the community.	Longitudinal case control survey. 2 formal control groups, in total 16 midwives: 11 community based midwives, 5 working in acute hospital labour ward setting.	Related to midwives training needs by self-assessment, not specifically about their role and how they think they are perceived.	This survey would have benefited from another method of investigation to clarify the points made.
Differences of midwives' behaviour depending on the environment they provided care in. Midwives were more relaxed when providing care at home, take on an informal approach and interaction with the woman became easier.	Random sample survey of 150 independently practicing midwives.	Limitations to the data collection as based on a survey.	Another method of data collection would have strengthened the findings.

## How Women Perceive the Midwife's Role

Findings	Methodology	Strengths and Weaknesses	CASP
<p>Women felt there was a lack of a clear image of midwifery in society.</p>	<p>Data collected from surveys with women and interviews with midwives. One woman and midwife representing each state and territory in Australia (8).</p>	<p>Data collected through a survey, therefore lacked depth.</p>	<p>Complies, except on research design where interviews with the women may have added richness to the data collected.</p>
<p>Women perceive the use of technology to be an important part of the midwife's role and perceive birth in hospital to be safer than at home or in a freestanding birth centre.</p>	<p>Triangulation of qualitative methods at 1 maternity unit. 46 women completed booking questionnaire, 44 were observed. 30 women completed a questionnaire at 34 wks gestation and all participated in an interview. Postal questionnaire completed by 30 women and participated in interview. 32 partners completed questionnaire, 28 were observed. 20 partners completed a questionnaire at 34 wks gestation, 20 also being interviewed. 19 partners completed a postal questionnaire. 12 midwives, 9 senior obstetricians and 15 GPs were interviewed.</p>	<p>The triangulation of methods provides a robust framework. The inclusion of different participants, including women, partners, midwives, obstetricians and GPs provides a pivotal vantage point of women's views and the influences that lead to their choice of place of birth. This study provides a valuable contribution to views on the role of the midwife.</p>	<p>Weakened on 1 point- only 1 maternity unit was included. The methodology used results in a comprehensive and robust study.</p>

<p>Found 50% of women participating found the midwife in labour to be uncaring.</p> <p>2 distinct categories;</p> <ul style="list-style-type: none"> <li>The midwife's humiliating behaviour</li> <li>The midwife's humiliating actions</li> </ul>	<p>Hermeneutic approach.</p> <p>67 Primigravid women.</p>	<p>Hermeneutic approach used.</p> <p>Based on primigravid women having a hospital birth.</p> <p>Provides important information, would have been advantageous to have compared women's views birthing in different environments or within different models of care.</p>	<p>The richness of this approach provides unique findings, which may not have been revealed with other study designs.</p>
<p>Women described how midwives 'got them through' labour. This seemed to be achieved by one to one support.</p> <p>The robust indicator of effectiveness was one to one support, rather than 'getting the woman through the process', a culture of hospital labour wards.</p>	<p>Observation of women and midwives' interactions (20 visits) and interviews with both women (30, 3 months postnatal period) and staff (15) in a standalone birth centre</p>	<p>Good methodology, using different methods of data collection.</p> <p>Relates specifically to care in a Birth Centre.</p>	<p>Complies. Study design gives a 360-degree perspective of the subject studied. Based on one site, therefore findings may only be applicable to this site, which the researcher acknowledges.</p>
<p>Women who rated themselves in a risk category of 'none' or 'low' reported that they experienced higher standards of care, greater help and encouragement and felt more involved with decision making if their birth experience was in a midwife led unit than those who experienced birth in a consultant led environment.</p> <p>Quantitative data showed women experiencing birth in a midwife led unit had shorter labours and were more likely to experience a normal vaginal birth than those experiencing a consultant led birth environment.</p>	<p>Self-completion postal questionnaires 8 days after birth sent to women. 9 units included (6 midwife led, 3 consultant led). 294 women who experienced midwife led environment and rated themselves as risk factor of 'none' or 'low' were included and 138 women who experienced consultant led birth environments.</p>	<p>Provides a unique perspective of women's experiences relating to place of birth. Only one method was used but across 9 units, which reduces bias.</p>	<p>Based on a questionnaire provides only superficial data, but includes multiple sites. Another method included would have added further depth to the information found.</p>

<p>Women who experienced a consultant led environment were more likely to have pharmacological analgesia than those experiencing a midwife led environment. Study implies different philosophies operating within different environments.</p>			
<p>Found differences between midwives delivering conventional care (by different midwives) and midwives delivering caseloading care (same or small group of midwives). Hierarchical and formal styles of communication used by the midwives delivering care conventionally, compared to the caseloading midwives who had less hierarchical and a more conversational style.</p>	<p>Observation of 40 interviews between women and midwives were observed.</p>	<p>Included observing interviews between women and midwives. The study took into account the views from an audit. It may have been more advantageous to have interviewed the women instead of relying on the audit evidence.</p>	<p>The audit evidence needed to be followed up with focus groups or interviews to have provided increased validity to the findings to supplement the observational work performed.</p>
<p>Women viewed hospital as a safer place for their birth experience. Women were unaware that midwives could deal with obstetric emergencies.</p>	<p>Survey of pregnant women across 12 maternity units in England, which offered different birth settings. 15 focus groups at 14 maternity units in England offering different birth settings, attended by 120 midwives and 6 student midwives.</p>	<p>Valuable study. Explored women's and midwives views. Women's views based on a survey, therefore study would have benefited from further exploration of the findings. Only touched on midwives views of their role. Did not investigate whether these low and high tech midwives practiced within a particular model of care or area of practice.</p>	<p>Complies, but further depth could have been gained from interviews with a sample of the women and midwives involved in the survey and focus groups.</p>

<p>Women reported high levels of satisfaction with care. Majority knew their carer through pregnancy, labour, birth and the postnatal period</p>	<p>Interviewed all midwives from the Albany Practice and 11 from King's College Hospital Trust, they also interviewed seven medical staff at varying grades, five hospital managers, two GPs who accessed the practice and two health visitors to discover their views and experiences of caseload midwifery. Consulted women who had received both Albany's services and that of King's College Hospital NHS Trust, surveying 447 women - 299 who had hospital births, 42 who had home births excluding Albany women and 106 women who were cared for by Albany midwives the care they received.</p>	<p>Based on a caseloading model. An evaluation of a model of care, not how they perceived the role of a midwife.</p>	<p>The numbers of women included in the survey were good, however no other method was used with the women. Use of another method would have provided a more robust design.</p>
<p>Women were more satisfied during labour if they were:  <ul style="list-style-type: none"> <li>·Treated with respect</li> <li>·Supported to give immediate contact with baby</li> <li>·Praised for their efforts</li> </ul>           Care they were least satisfied with:  <ul style="list-style-type: none"> <li>·Keeping their partner informed of progress</li> <li>·Permitting participation in decision making</li> <li>·Help given with initial breastfeed</li> </ul> </p>	<p>Descriptive transversal study. Survey of 316 women.</p>	<p>Collected via a questionnaire, therefore does not allow for further exploration.</p>	<p>The design of this study could have been improved with addition of other methods to investigate the findings of the survey.</p>

<p>Women reported high levels of satisfaction with care. Majority knew their carer through pregnancy, labour, birth and the postnatal period.</p>	<p>A quasi-experimental descriptive study. 263 women receiving care by the same midwifery team in pregnancy, intrapartum and the postnatal period, compared with 413 women receiving standard hospital care randomly.</p>	<p>Based on a caseloading model. An evaluation of a model of care, not how they perceived the role of a midwife.</p>	<p>The design of this study provided a robust platform for data collection. Different methods were used including a survey, interviews and observation involving both women and midwives. This gave a 360-degree view of the team and hospital care. This provided an in depth evaluation and compared two types of care in different settings.</p>
<p>Women wanted a birth with minimal intervention, but viewed safety as an overriding factor. In labour women relied on the midwife to oversee care. Trust gained by the midwife having prior contact with her before meeting her in labour. Factors inhibiting relationships were; ·Finding alternative pain methods ·Staffing levels, inhibiting time woman felt she needed with midwife ·Lack of emphasis on evidence based care and environmental constraints of the labour room</p>	<p>Observation of 5 birthing mothers and their midwives. Pre and post birth interviews.</p>	<p>Data collected by pre and post birth interviews. Also through observations of relationships between women and midwives in labour. Sample size was small- 5 midwives and 5 women. But greater depth provided by different methods used.</p>	<p>Mixed methods used, which adds depth. Only one site used, therefore findings may be particular to this site only.</p>



<p>Women reported high levels of satisfaction with care. Majority knew their carer through pregnancy, labour, birth and the postnatal period.</p>	<p>A team of four midwives provided the care during pregnancy, labour and the postnatal period, to 503 women at low obstetric risk, over a two-year period. Compared with standard hospital care randomly allocated to 498 women.</p>	<p>Based on a caseloading model. An evaluation of a model of care, not how they perceived the role of a midwife</p>	<p>Data of birth outcomes and questionnaires from the women were used. Another method to supplement the women's views would have been helpful to give further clarity. Interviews or focus groups with the midwives would have provided another dimension to the study.</p>
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## Partners Perceptions of the Midwife's Role

Findings	Methodology	Strengths and Weaknesses	CASP
<p>Communication between the father, their partner, the midwife or other health professional made a significant difference to the control and involvement fathers felt at the birth. This contributed to either a positive or negative experience.</p> <p>Fathers felt on the periphery of events during labour.</p> <p>Fathers were disembodied during their partner's pregnancy and did not connect with the baby until it was out of the womb. They used technical language when talking about the birth experience, which may have helped them to disconnect from the process.</p> <p>They appeared to have great faith in the midwives and viewed the intrusion of doctors with ambiguity.</p>	<p>A Heideggerian hermeneutical phenomenological approach was used.</p> <p>Semi-structured interviews were used at two time points (antenatal and postnatal period).</p> <p>A purposive sample of 11 expectant fathers was included at one large maternity unit.</p>	<p>A unique approach providing valuable information in relation to partner's perceptions of the midwife's role.</p> <p>The study shows depth and breadth in relation to the subject.</p>	<p>Does not distinguish between models of care or birth environments and is related to one site. The depth of the investigation does make up for these limitations.</p>
<p>Men perceived midwives as providing information in a way they could understand and were willing to listen to how they were feeling.</p> <p>They believed midwives encouraged them to ask questions 'most of the time'.</p> <p>1 in 5 did not feel midwives encouraged them to ask questions and 1 in 6 felt midwives were not willing to listen if they wanted to talk. 1/3<sup>rd</sup> felt midwives ignored them, talking mainly to their partner. 7% perceived midwives avoided eye contact.</p> <p>Midwives communication skills were rated more highly than GPs and doctors.</p>	<p>Based on 2 postal questionnaires, completed by men (all partners presumed as being male in this study) when their partner was 34 weeks pregnant and a second one six months later.</p> <p>817 men replied to the first questionnaire (37% response rate) and 463 replied to the second (57% response rate).</p>	<p>Interesting that all partners were perceived to be men by the researchers. It was unfortunate that the model of care or birth environment the men experienced was not identified, as this would have added a different dimension to the study.</p>	<p>Falls down on no identification how many maternity sites and types of care and environment the sample scoped.</p> <p>Questionnaires provide only superficial data; interviews would have added a deeper exploration to this study. The sample size was good, but the response rate overall was poor, therefore may not be a true representation, piloting the questionnaire first may</p>

<p>Men were less satisfied with how midwives communicated with them after the baby was born. Men visited by a midwife at home tended to be more positive about midwifery care.</p>			<p>have helped. A commercial company was sourced to provide the sample, this can be viewed as a tool to access a good sample, but it may also be viewed as biasing the results, although there appears to be no commercial gain for the company involved. The researchers did not state the limitations of their research.</p>
<p>Partners experiencing birth centre care assessed care as more positive than standard (consultant led) care. Attitudes by midwives were assessed as being more positive by partners, feeling they were treated with greater respect and felt the midwife was more supportive than those experiencing standard care.</p>	<p>Uses quantitative and qualitative methods. Randomised control trial: birth centre care versus standard (consultant led) care. Questionnaires at 2 points following the birth- one concerning demographics, the other assessing experiences of care. 1143 partners included across 7 maternity units. Questionnaire response rate= 99% birth centre group and 94% standard care group.</p>	<p>The randomised control trial dissolves the right to choose the birthplace environment, which results in loss of autonomy and control for both the women and the partners. However it does allow for statistical analysis to quantify the data. The inclusion of qualitative data enriches the study, but is of a superficial nature in the form of questionnaires. An excellent sample size is achieved, with excellent response rates for the questionnaires.</p>	<p>As CASP is a tool for qualitative research this study falls down on only one qualitative method being used. This study would have benefited from further qualitative exploration of the findings from the questionnaires.</p>

## **2.4 CONCLUSION**

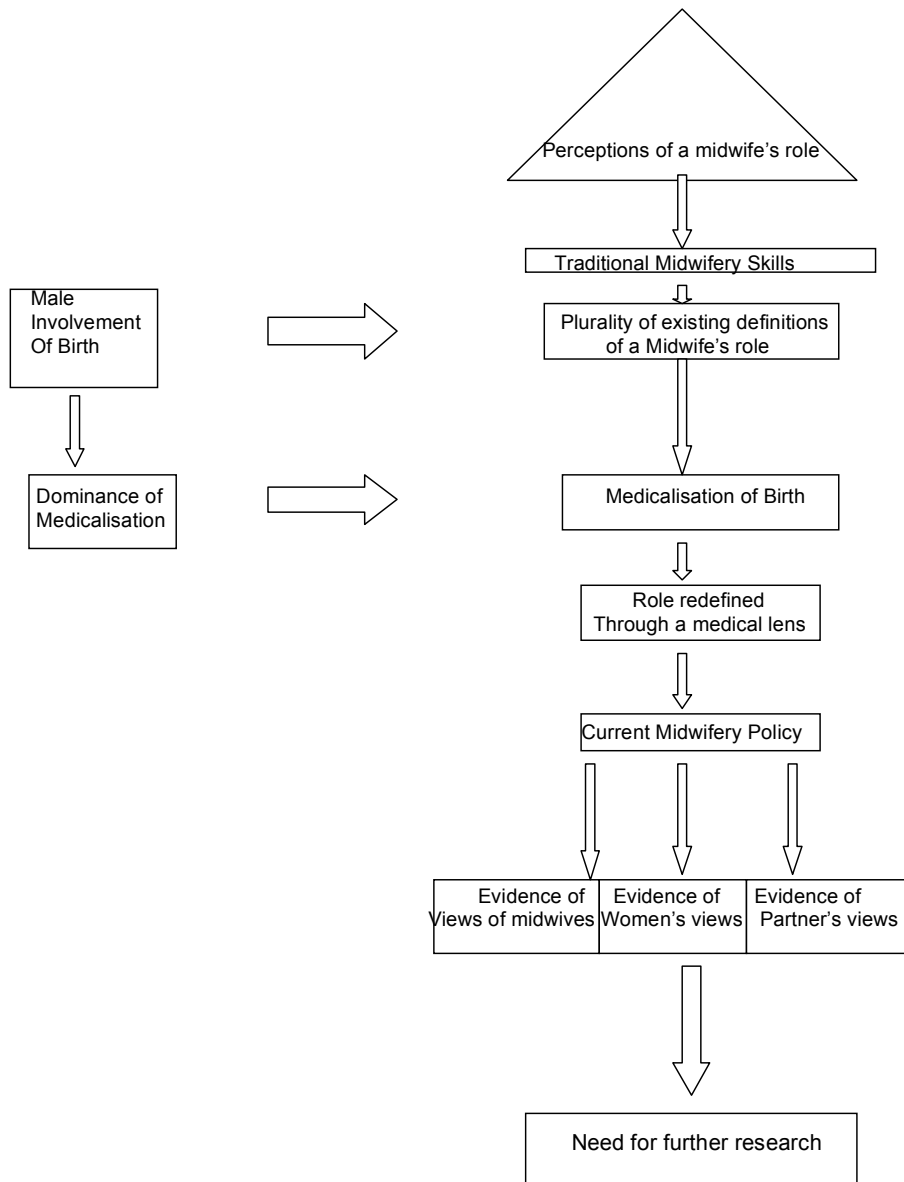
The sections in Chapter 1 provide a firm foundation on which to build a study about perceptions of the midwife's role. Section one has provided a detailed account of the background surrounding the subject of the thesis, to allow for a better understanding of how and why perceptions of the midwife's role have 'come to be'. Section two provides a detailed review of the evidence already available relating to perceptions of a midwife's role. It has shown a gap in the detailed nature of this subject to justify the need for a study. This will provide a valuable addition to the knowledge already available, informing us with a deeper insight into perceptions of a midwife's role.

I have identified that a study would be beneficial to add to the knowledge base. Chapter 3 moves this thesis forward into the first phase of this research study.

Through this thesis commencing with this chapter, I will provide a flow chart to map my journey through my experience. This will build to provide a detailed account of where I have 'come from' to where I have 'come to'.

Please see figure 2.3.4.5 below.

**Figure 2.3.4.5**  
**Research Journey**



## **CHAPTER 3**

### **METHODOLOGY: THE FIRST PHASE**

#### **3.1 INTRODUCTION**

This chapter will discuss the first phase methodology of this research study. The previous chapter provided an understanding of the background and of the literature, which has influenced knowledge construction concerning perceptions of the midwife's role. This has provided a platform to build upon.

The first phase of this study uses the knowledge already gained in chapter 2 to explore perceptions further. The literature pertaining to partners and fathers provides an important area for discussion, but due to time constraints these perceptions cannot be explored further. Women are at the centre of maternity care; therefore the starting point of this exploration has to be prioritised with their views. The findings however may include aspects relating to partner's/ father's, therefore the knowledge already gained in the literature review may be valuable further along this journey.

Methodology and the research design relating to the first phase of this study will be discussed, including ethical principles, reflexivity and my experiences of the Ethics Committee. In the first part of this chapter feminism is explored in relation to sourcing an approach that will provide a deeper exploration into the views of women and midwives. It provides understanding of how patriarchy, and medicalisation has influenced birth today and their pivotal relationship in how women have 'come to know' about the role of the midwife. Kingdon (2007) uses the term of women 'coming to know' when referring to women's 'situated knowledges' in relation to vaginal and caesarean birth choices. This term assists in my explanation of perceptions of the midwife's role; therefore I have chosen to use it within the thesis. Women's perceptions of the midwife's role, has to be viewed through their eyes to understand how they 'come to know' within contemporary midwifery.

This discussion progresses into chapter 4 to discuss the methodology of the second phase of this research study.

### **3.2 FEMINIST PERSPECTIVES: CHOOSING A PATH**

This section of the chapter explores feminism in relation to sourcing an approach that will provide a deeper exploration into the views of women and midwives. It provides an understanding of social influences on the role of the midwife.

Firstly I define feminist theory and its relevance to the world. Feminist theory has developed over time, therefore I will move through from first to third wave feminism discussing their relevant aspects to this study and how they have all contributed and evolved with the developing world around them.

#### **3.2.1 Defining Feminist Theory**

Feminism is concerned with subordination of women, recognising that inequality exists between the sexes. It seeks to expose and understand women's experiences. One of the main features of feminist theory has been its ability to influence social change through not having any boundaries and entering into previous forbidden territories. Feminist theory is important in relation to women and midwives' views of the midwife's role, as gendered influences on the role have moulded it into its present structure.

The commonality that feminists share is their desire to produce knowledge that will improve women's lives. They share political commitment to make change happen for women. However, feminists have different views on how to liberate women from subordination and hold different epistemological positions and theoretical perspectives. Feminist theory has developed over time, one influenced by another, many feminist writers have changed their stances with the developing social world. Feminist theory is a continually advancing process, changing with the surroundings it exists within. To understand the changes that have occurred and the struggles for equality it is necessary to explore how feminism has influenced women's and midwives' lives.

Below is a summary of feminist theory in relation to how views of the midwife's role may have developed through history.

### 3.2.2 First wave: Recognition of Inequality

First feminist thought was described through the 18<sup>th</sup>, 19<sup>th</sup> and early 20<sup>th</sup> century. Feminists at this time claimed that the “right” must be given priority over the “good”. Tongue (2009) explained, we all have the “right” to choose what we want as long as we do not deprive others of their choices while we are doing it.

Mary Wollstonecraft wrote in *A Vindication of Women's Rights* in 1792 that the forces of industrial capitalisation had started to draw labour, which had previously been done around the family home into public places of work. For the first time women were left at home, the biggest impact initially being on married bourgeois women who had no incentive to work outside the home and had several servants. Wollstonecraft (1792) described these women as birds confined to cages, having nothing else to do but preen themselves and

*“Stalk with mock majesty from perch to perch”*  
(Wollstonecraft (1792:56).

She described these women as sacrificing health, liberty and virtue for whatever prestige, pleasure and power their husbands could provide. She argued that they were being denied their chance to develop ‘rational’ powers, therefore not acquiring any concerns or commitments beyond personal pleasure, describing this as becoming ‘overly emotional’. She concluded that if men had been in the same situation as women, they too would have behaved the same. Interestingly Rousseau (1792) described how ‘rationality’ was the most important educational goal for boys, but not for girls. He went on to discuss that the ‘rational’ man was the ideal complement to the ‘emotional’ woman. Wollstonecraft (1792) urged women to become autonomous decision makers and become more ‘rational’, which she felt could be achieved through education. She urged women to behave the same as men.

One hundred years later John Stuart Mill and Harriet Taylor Mill (1832, 1851, 1869) agreed with Wollstonecraft on her ideas of women becoming more ‘rational’, but extended the meaning of it to include calculative reasoning, using your head to get what you want. They moved onto the thoughts that if sexual equality is to be achieved, society has to provide women with the political rights, economic opportunities, as well as the same education provided to men. They



both believed that giving women the 'vote' would give them power to not only express their own political views but would lead to changing systems, structures and attitudes of others.

The move towards abolition of slavery was fundamentally fought for with United States of America Women's Rights campaigners. These women were silenced at the 1840 World Slavery Convention by the men abolitionists, as they did not want women's liberty struggles associated with blacks' liberty struggles. Therefore women were left to fight on for liberation in the US alone. The National Woman's Suffrage Association fought hard for equal rights, but had to confine all of its activities and resources to securing the vote. This right materialised in the U.K in 1918. This did not come for fifty-two years of struggle in America, until 1920.

In the early twentieth century women wanted economic opportunities and sexual freedoms as well as civil liberties. Women formed action groups, the National Organisation for Women (NOW), the National Women's Political Caucus (NWPC) or the Women's Equity Action League (WEAL) to put pressure onto institutions to highlight women's need for equality.

Interestingly, women began to voice an interest in pain relief in labour. The lead came from Queen Victoria and Fanny Appleton Longfellow and followed by feminists across the U.K and America to demand the right to manage labour pain with the use of drugs. The right to receive pain relief was seen as an important political issue by many feminist activists (Wertz and Wertz 1977; Reissman 1983; Leavitt and Walton 1984; Leavitt 1984, 1986). They used aggressive campaigns to pressure governments and obstetricians into the right of women to use opioids and inhalation analgesia during childbirth (Leap and Anderson 2004). This argument was not necessarily about the drugs or women's desire to be seen as 'rational', but for medicine to take note to be responsive and respectful to women, for them to have expanded choices in childbirth. Control over one's body and reproductive life (Beckett 2005).

### 3.2.3 Second wave: Different Perspectives of Seeing

#### 3.2.3.1 Liberal Feminism

Liberal feminism is drawn from the earliest feminist thoughts of the first wave. Feminists who adopt a liberal approach advocate if women are given a level playing field, they will demonstrate their equal worth. This can be related to the struggle for midwifery to be viewed as a profession and the fight for the Midwives Act of 1902. Midwives wanted to be given the same level playing field as the obstetricians, to keep normal childbirth values protected within their safekeeping. This feminist thought is based on the principles of women and men being equal in potential, but that differences exist from social expectation, including the differing ways boys and girls are treated from birth, as well as from discriminatory legislation (Abbott and Wallace 1997). Liberal feminists believe that these barriers can be overcome through education, but many criticise this as being too simplistic, as it takes no account of educational, social and financial barriers also faced by women (Gatens 1983, Turner 1987, Annanadale 1998). This is appropriate to my study as it takes into consideration where the midwife is placed within the organisation, but also takes into account where the woman receiving care is placed. Both of these are relevant to how the role of the midwife is perceived.

Within this section of feminist approaches there were moves away from the classical thoughts of liberal feminism into a new branch of welfare liberal feminist thought, also called egalitarian. This new era moved away from women trying to 'have it all' and be 'superwomen' at home and the workplace, but to work together with men to share the load and share the traditional social roles. Betty Friedman, in *The Fountain of Age* (1993) appeals to both men and women to grow and change. She urges them to move away from polarised sex roles and creatively develop whichever side of them they neglected in their younger years. Tong (2009) agrees with this view of androgyny to counteract society's traditional tendency to value masculine traits or men more than feminine traits or women.

*"If society encouraged everyone to develop both positive masculine and positive feminine traits, then no one would have reason to think less of women than of men. Discrimination on the bases of gender and biological sex would cease"*

(Tong 2009).

Jagger (1983) disagrees. She argues that the neutral, rational, free, autonomous person they are defining is based on a “male” self. The body and its functions do not come into question through the mind of a liberalist, as the mind is viewed as superior. Jagger (1983) describes how men are distanced from nature due to their undemanding reproductive and domestic roles, so tend to devalue the body and its functions. Males tend to spend their time cultivating the life of the mind. In contrast women have close ties to nature through their reproductive and domestic roles and have spent time caring for bodies, therefore place greater value on the body and its functions. Jagger (1983) identified that men seemed to dominate western culture’s ideas about human nature, due to men taking over the field of philosophy early on in history. This has resulted in the acceptance of the mind being a priority in comparison to the body. Therefore, normative dualism leads to devaluation of the body and its functions. This then leads to political solipsism and political scepticism. The result is valuing the mind over the body and the independence of the self from others is the creation of a politics that puts an extraordinary premium on the liberty of a person’s ability to think or do (Jagger 1983). This puts us back in the same position as before, women seeking maleness. Even though liberalism has moved into new thought, it still retains the male view and outlook as being superior and that females have to move towards it, rather than retaining their values and uniqueness.

Liberal feminism offers midwives the same level playing field within the institution, so that the midwife is viewed as having the same power and control. But by taking this stance the midwife is just re-enacting the role of the doctor, not changing the structure. Midwives performing specialist roles are an example of this, the majority of these posts are designed to take on doctor’s roles, for example, the ventouse practitioner and do not develop midwifery practice, therefore we are devaluing our profession. Mc Loughlin (2003) pointed out that to have the rights of men, liberal theories demanded women to behave the same as men. Cornell (1998) claims patriarchy generates a template of what the good life should be.

*“Women lack equality because they are judged against the norm and lack the right to conduct their own vision of what their life should be”*  
(Cornell 1998).

This has led me to believe that I cannot give a true insight into subordination of these women by choosing this stance, as it advocates re-enactment of male roles and behaviour.

### **3.2.3.2 Radical Feminism**

Radical feminism is another feminist approach associated with the second wave. Women's rights groups were the basis for this feminism forming. The aim of these groups was to eliminate discrimination relating to education, legal and economic policies (Hole and Levine 1971). They worked towards reforming the 'system' through working for government agencies, being appointed to commissions on the status of women, or joining women's educational or professional groups.

Then new groups focussing on revolutionising rather than reforming began to emerge and rather than working towards reform they participated in radical social movements (Hole and Levine 1971). These revolutionary feminists were called 'radical feminists' and moved feminism into the realm of consciousness-raising (Tong 2009). Groups of women came together to discover their own individual experiences could be shared and found other women had the same experiences. Empowered by the realisation that women's fates were profoundly linked, radical feminists proclaimed that the 'personal is political' and that all women are 'sisters'. They insisted that men's control of both women's sexual and reproductive lives and women's self-identity, self-respect and self-esteem is the most fundamental of all the oppressions human beings visit on each other (Tong 2009). Then there became a split into two groups, the radical- libertarian feminists and the radical-cultural feminists, believing in different ways of fighting sexism.

The libertarian view was for women to be androgynous, to embody both good feminine and good masculine characteristics. This led to the description of "the bitch", blatant, direct and arrogant. She wants to embrace as part of her gender identity those masculine characteristics that permit her to lead life on her own terms (Freeman 1973). Rubin (1975) described how the sex/gender system is a set of arrangements by which a society transforms biological sexuality into products of human activity. Tong (2009) describes this as meaning, that within a

patriarchal society gender identities and behaviours serve to empower men and disempower women. This society convinces itself that cultural constructions are somehow 'natural' and that people's 'normality' depends on their ability to display whatever gender identities and behaviours are culturally linked with their biological sex and therefore, these rigid gender roles are used to keep women passive.

Millett (1970) argues that unless the clinging to male supremacy as a birthright is forgone, all systems of oppression will continue to function simply by virtue of their logical and emotional mandate in the primary human situation. She states that male control must be eliminated if women are to be liberated. Firestone (1970) looked to the future to free women from their obligation to procreate with men to reproduce, artificial reproduction could provide the catapult. Interestingly she believed that technology and advancement in science would free women from oppression. She argued that women would be free of their gender roles at the level of biology, women would no longer have to be passive, receptive and vulnerable, sending out 'signals' to men to dominate, possess and penetrate them in order to keep the wheels of procreation spinning. Firestone (1970) proclaims that the joy of giving birth is a patriarchal myth, describing pregnancy as barbaric.

The cultural view is related to nature and human relationships with it. French (1985) observed that early humans lived in harmony with nature and that societies were matricentric, where the mother played the harmonious participation in the groups survival orientated activities of bonding, sharing and harmonious participation in nature. Nature was friend and as a sustainer of nature and reproducer of life, woman was also friend (French 1985).

French (1985) makes an important point that the more control humans gained over nature the more they separated themselves from it both physically and psychologically. This alienation then grew into hostility and fear. She argues that these negative feelings intensified men's desire to not only control nature, but to control women, as they were regarded as being associated with nature on account of their role in reproduction. Out of this control grew patriarchy, a hierarchical system that values having power over as many people as possible.

In contrast Daly (1973) argued that God is the paradigm for all patriarchs and that until he is dethroned from men's and women's consciousness, women will never be empowered as full persons. Daly (1973) describes god as rejecting women, which is reflected through women being viewed as the second sex. Daly (1978) argues that women need to strip away false identity, which she views as femininity, which patriarchy has constructed for her. Then and only then can she have lived her life in a matriarchy rather than patriarchy (Daly 1978). In relation to childbearing (Hibri 1984) argues that technological reproduction does not equalise the natural reproductive power structure, it inverts it. So rather than liberating women, reproductive technology consolidates men's power over women. Tong (2009) says that it gives them the ability to have children without women's aid. In 1979 Rich wrote how men had taken the birthing process into their own hands. She argued that male obstetricians had replaced female midwives, substituting midwives "hands of flesh" for their "hands of iron". She described how male physicians wrote the rules for pregnancy and birth, even dictating to women how to feel during childbirth. These rules clashed with women's intuition and women became confused, this led to lack of control of their bodies. Others agreed with Rich's (1979) stance in which patriarchal authorities<sup>17</sup> have used medical science to control women's reproductive powers, these included Dworkin (1983), Atwood (1985), Corea (1985), Rowland (1985) and Dworkin (1983). They claimed infertility experts had joined with gynaecologists and obstetricians to seize control of women's reproductive powers. Corea (1985) went a step further arguing that if men control the new reproductive technologies, men will use them not to empower women but to further empower themselves.

When comparing the two stances libertarian and cultural, my inclination pulls me towards the cultural stance. But perhaps a mixture and a crossing over of the two is the way forward, one argument criticising radical feminism is that not all women are victims and not all men are oppressors. Rowbottom (1972) points out that there are examples where men have supported women in their liberation struggles. Radical feminism also depends heavily on interpretations of masculine and feminine qualities; each individual can interpret these differently.

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<sup>17</sup> See earlier point for definition of patriarchy in French (1985)

### 3.2.3.3 Marxist and Socialist Feminism

Marxist feminism is based on the principle of class inequality rather than sexism being the fundamental cause of women's oppression. Even though gender is not viewed as a fundamental cause it is still linked (Annandale 1998). This line of argument may be relevant to my study if women view the midwife as being within a lower class order within the organisation structure, where men are within a higher class structure leading to exploitation and oppression of them. This may be related to patriarchy not class per se. But it is a fact that midwives are lower down the organisational hierarchy and receive less pay than their obstetrical colleagues, therefore can be related to this economic concept.

Feminists working within a classical Marxist approach, advocate that class is seen as a division which gives rise to conflict and change. Relations of production are central to this division and workers are seen as exploited and oppressed through the accumulation of profit (capital) from their labour power.

Marx stated:

*“ The mode of production of material life conditions the general process of social, political and intellectual life. It is not the consciousness of men that determines their existence, but their social existence that determines their consciousness”*  
(Marx 1972:20).

Marxist feminists believe that this came about due to men's work increasing outside the home and production gaining importance. Women were left at home to continue keeping the home and family, but with this came a decrease in the status of women. As men now owned possessions, sociologically these were determined as more valuable than women. Men wanted to pass these possessions onto their biological children, therefore men exerted pressure to convert society from matrilineal to patrilineal (Tong 2009). This was the beginning of property ownership and material possession importance, which impacted on how women became second-class citizens compared to men who were viewed as first class within society. Marxist feminists who decided that women's sex class as well as economic class plays a role in women's oppression began to refer to themselves as socialist feminists (Tong 2009), therefore breaking away from classical feminist thought. The socialist feminists became two groups: those who believed in a two-system explanation of

women's oppression; those that believed in an interactive system explanation of women's oppression.

The two-system thought was the classical Marxist position of class power being the oppressor combined with the radical feminist view of sex power being the oppressor. Mitchell (1971) argues that women's status and function are determined by their role in reproduction as well as production. Jaggar (1983) agreed that all women, not dependant on their work role, are alienated in way that men are not. She discusses how motherhood can be an alienating experience, especially when men mostly or exclusively decide the policies and laws that regulate women's reproductive choices. Jaggar (1983) points out that women can be alienated from the product and the process of their reproductive labour, for example, an obstetrician may try to take control of the birthing process, performing unnecessary medical intervention or advocating an unnecessary caesarean section.

The interactive system is based on capitalism and patriarchy as two equal partners working in an interactive way to oppress women. Young (1981) argues that under capitalism women experience patriarchy as unequal wages for unequal work, sexual harassment on the job, uncompensated domestic work and the pernicious dynamics of the public-private split. She insisted that we do not need one theory to discuss gender-neutral capitalism or another to explain gender-biased patriarchy; we need a single socialist theory of gender-biased capitalism instead. This is an argument I support moving forward from the original Marxist view and that this was a collection of thought from the basic stance. As women moved into the productive workplace it had not made them men's equals, there or at home. Therefore, socialist feminists moved beyond class as the only category of women's subordination (Holmstrom 2002).

My reaction towards this theory is that there are limitations to it and it does not fully explore the experiences of the cultures the women are immersed in for this period of time through their pregnancy and in the postnatal period. Therefore, I have chosen not to use this type of feminist argument as the basis for my theory.



### **3.2.4 Psychoanalytic Feminism**

Psychoanalytic feminism moves on from second wave feminism into new realms. Before I explore the work of these particular feminists I will briefly explain psychoanalytic feminism and its relevance to this thesis and the body of feminist literature. Psychoanalytic feminism maintains the fundamental explanation that the way women act is rooted deep in women's psyche, specifically in relation to how women view themselves in society (Tong 2009). Freud's (1968) theory of biology being linked to sex and gender relationships, specifically in relation to the Oedipus complex angered many feminists. Friedan (1974), Firestone (1970) and Millett (1970) believed that women and men's gender identity, gender behaviour and sexual orientation are not the result of biological facts. The values of women cannot possibly be ignored, Freud's (1968) theory is completely irrational and discriminatory to women, when his whole argument is around not having a penis and this theory is just incomprehensible. Women are blessed with the power to give birth, which is ignored. Millett (1970) describes Freud as succeeding in converting childbirth, an impressive female accomplishment, into nothing more than a search for a female organ.

Adler (1927), Horney (1973) and Thompson (1964) agree that genitals do not determine our destiny and that creativity allows us to have the power to shape our lives in any direction we want, man or woman. They agreed that the problem was within patriarchy. Thompson (1964) argues that women's guilt, inferiority and self-hatred are grounded not in biological facts, but in society's interpretation of these facts. The resolution to this is the transformation of the legal, political, economic and social institutions that shape society, which is a necessary step in the transformation of women's psychology.

I am drawn towards the feminist thoughts of Lacan (1968). He describes the pre-oedipal phase as the 'Imaginary' phase, where the infant knows no boundaries, he or she has no concept of where the mother's body ends and her or his own begins. During this stage of development the infant is neither, feminine or masculine. In the second phase, 'mirror' phase, the infant thinks the image of himself or herself, as reflected through the 'mirror' of the mother's gaze, is her or his real self. Before the infant can see itself as a self, the infant

must see itself as seen by the mother. Lacan (1968) describes this as the basis for all relations, the self always discovers more about itself through the eyes of the other. The third, Oedipal phase includes maturation of the child, where he/she views herself as separate from the mother; she is now seen as the other, someone who he/she must communicate with. Due to the complications of language, she can never truly fulfil those wishes.

The mother child relationship is then further eroded by the intervention of the father. In this phase boys experience the splitting from their mother differently to girls. The boy rejects identification with the mother, eschewing the undifferentiated and silent state of the womb and bonds with his anatomically similar father, who represents the Symbolic order, the word. Through identification with his father the boy not only enters subjecthood and individuality, but also internalises the dominant order, the rules of society. In contrast, because of her autonomy, the girl cannot wholly identify with her father or misidentify with her mother, therefore, the girl cannot fully accept and internalise the symbolic order. He concluded that women are virtually excluded from the symbolic order or if they enter it are repressed within it. This is the result of the language used as it consists only of masculine words and cannot express how women feel, women must either babble outside the symbolic order or remain silent within it.

Irigaray (1985) claimed that within the 'imaginary' there is either male/masculine imaginary or female/feminine imaginary. She viewed women's total existence in the imaginary or wordlessness in the symbolic order as two situations full of untapped possibilities for both women and society. She also pointed out that the only feminine we know is the masculine interpretation of feminine, which therefore, makes the feminine masculine. She expressed concern with trying to verbalise what feminine is, as this would allow us to be caught up in masculine representations. She also discusses how masculine discourse has never been able to understand woman or the feminine, as anything other than the reflection of man or the masculine. This makes it impossible to think the feminine is feminine within the structures of patriarchal thought. Men only see reflections of men when they look at women, not a reflection of the woman. Irigaray's (1985) solution was for women to create their

own language. She also suggests women should take men's images of women and reflects them back in magnified proportions, urging women to take every opportunity to raise a 'ruckus' in the symbolic order. The theory around the symbolic order fits in with the language used within medicalised childbirth and the patriarchal system within which childbirth is now contained. I do find it disappointing that Lacan and Irigaray use the association to Freud by discussing the pre-oedipal and the Oedipal phase, they are so free and creative around their theories it is regrettable that they did not describe them as a different system. Irigaray (1985) is closely related to Kristeva's (1990) views of the world.

Kristeva (1990) brings to the theory a different view of language. She describes two types: semiotic being maternal/poetic language, which allows us to express feelings; symbolic being paternal/logical language, which allows us to provide rational arguments. Kristeva (1990) believes the semiotic exists within and outside the symbolic order and that a liberated person can move between the spaces of the semiotic and symbolic aspects within the symbolic order. She does not believe that the semiotic should take over the symbolic within the symbolic order as she argued this would destroy the symbolic order and civilisation with it. Kristeva (1990) does not restrict biological women to the feminine or the biological male to the masculine, but maintained that when the child entered the symbolic order they would choose to be more feminine or more masculine. This breaks the traditional concepts of sexual difference and allows the person to be more fluid like. Within the language used in childbirth, the semiotic is stifled by the symbolic and balance has to be found. The crux of the matter is whether the symbolic order will allow balance to exist, due to its powerful influence within medicalised childbirth environments.

### **3.2.5 Postmodernism/ Postmodern Feminism**

Postmodernism does not try to resolve the problems of other positions, but starts from a different place and proceeds in other directions (Smart 1990). This feminism gives more space to move and explore perceptions of women and midwives as it recognises multiple truths. It rejects the notion of grand theories. It represents a more radical change in thinking than that of feminist empiricism or feminist standpoint epistemology, in that it completely rejects the possibility of the objective collection of facts and insists that knowledge is rooted in the values and interests of particular groups (Waugh 1998). Postmodernism recognises that each person is unique; we are not all the same, each of us with our own struggles and prejudices. The most appealing aspect of this for me is that within feminist postmodernism there is not one truth but many truths, none of which are privileged, and these different truths exist within different discourses (Flax 1987; Abbott and Wallace 1997).

Flax (1990) describes the 'enlightenment world' as a figment of people's imagination and that truth is whatever power proclaims it to be. Most people still operate within this framework and it is particularly relevant to my study and the beliefs within health care institutions. Derrida (1978) focused on the symbolic order. He observed that the symbolic order regulates society through the regulation of individuals. He used the term 'deconstruction' to theorise understanding of words; for example, dog does not depend on the physical reality of any particular dog or the idea of a dog in general. But, it does depend on other words on a very long chain of 'signifiers' that refer to nothing over and beyond themselves'. Words do not stand for pieces of reality, but reality eludes language and language refuses to be limited by reality.

Foucault (1973) is a post structuralist; he explored the varied dynamics of power, which are constructed within different levels of society and between different types of actor. Even though he has not directly written about midwives, he has provided us with greater understanding of the power relations within a hospital culture, which can provide insight into how the midwives' and women's views are formed about the role of a midwife. When analysing the organisation of state power in the eighteenth century he observed 'micro techniques of power that turn man (his term), in particular his body into an object of

knowledge and that knowledge into a mode of control and regulation' (Foucault 1973). In the nineteenth century institutions, including hospitals began to classify and monitor the body, so that its functions and failures could be calculated and regulated. Foucault believed that discourses are present within society that are made up of rules that authorise what is the correct form of speech, action or word within its boundaries. Feminists argue that this theory fails to analyse gender and inequalities between men and women, material structure of power and claims to rights on behalf of women. It also fails to make judgements about harm and evil (McLoughlin 2003).

I think that postmodern feminism does fit as a way of exploring my research question but does not fully allow exploration of women and midwives relationships with technology, as identified in some of the literature explored.

### **3.2.6 Third Wave: Seeing With 3D Spectacles**

Following on from what had been learnt from second wave feminism of the 1980s, there is a new third wave, which developed in the 1990's. This wave provides new meanings of how perceptions of a midwife's role are formed in present day culture.

The movement arose as a response to perceived possible failures and a backlash against initiatives and movements created by second-wave feminism. It has also delved into new areas not previously ventured into, for example, technoscience and anthropology. Fraser (1992) called this 'counter public spheres', where feminists are delving into places not usually understood and linked to rationality and change.

Technoscience draws on both science and technology together. Feminist technoscience uses influences from feminist writers and authors of technoscience to create a basis of understanding. Each author has their own genealogy, but they have read from and learn aspects from each other's work. Pickering (1992) and Latour (1993) are authors of technoscience, while Leigh Star (1994) Suchman (1994) and Haraway (1988, 1991, 1997) draw on feminism and technoscience, while also having their own unique roots. Relating feminist technoscience theory may be appropriate for this study, but it feels as

though I may be pulling away in one direction and until I am aware of some of the findings I m reluctant to apply it at this stage of my journey.

Anthropology can be described as the study of humanity. Anthropology has origins in the natural sciences, the humanities, and the social sciences. In the first century these fieldwork studies were carried out by men and were not generally related to childbirth. Levi-Strauss (1967), Paul (1975), Paul and Paul (1975), all examined birth, in relation to rituals and its practitioners. It was not until the 1960s that women began to enter this world of anthropology and studied birth from the 'inside' and to understand birth as a joined up system of knowledge and praxis. The main contributions in this field have come from Mead and Newton (1967), Kitzenger (1980), Newman (1981), Jordan (1987) and Davis-Floyd (1997). It is an important knowledge emporium to use in relation to this study, to help understand perceptions of the midwife's role.

Third wave feminism considers individuality, complexity and less than perfect personal histories (Walker 1995). Feminists from the third wave believe that second wave feminism was too restrictive, that it put identities on people, putting them into a 'box' (Roiphe 1993, Walker 1995); However some agree that they have only come to this place due to previous feminist waves (Dicker and Piepmeier 2003, Henry 2003). Interestingly, Wolf (1993) talks about third wave writers as a daughters' movement. This suggests feminism has moved on a generation, that it has grown up and learnt from its mothers of the second wave. There has been a backlash against third wavers as women who view themselves as post feminists contest the third wave by believing that women have all of the legal and social rights they need as protection to function on an equal footing in contemporary society, therefore there is no need for a third wave:

*"A movement when women's movements are, for whatever reasons, no longer moving, no longer vital, no longer relevant; the term suggests that the gains forged by previous generations of women have so completely pervaded all tiers of our social existence that those still 'harping' about women's victim status are embarrassingly out of touch"*  
(Siegel 1997:75).

Third wavers argue otherwise that we must still take into account power relations concerning gender, race, class and sexual orientation. We must also

be aware that western society is still propelled by capitalism and shaped by the operation of invisible systems of power and privilege. Therefore, we owe it to ourselves to take action against this and to try to make change. There are still so many unresolved issues. Baumgardner and Richards (2005) sum this up by asking:

*"Why don't we have a totally activist, voting, engaged citizenry? Why do so many issues remain unresolved? Why do shelters have to turn away homeless people? And why don't more women hold political office? Where is the discontent between these would-be revolutionaries and the pressing issues?"*

(Baumgardner and Richards 2005:13).

Female representation in the media continues to be a concern to third wave feminists. Germaine Greer (1999), who is of the second wave era, discusses her frustration with the media of what she suggests her daughters of the third wave will have to contend with. She discusses how the media attempt to portray girls behaving badly or have been given the label as a 'ladette'. She states that:

*"The propaganda machine that is now aimed at our daughters is more powerful than any form of indoctrination that has ever existed before...to deny a woman's sexuality is certainly to oppress her, but to portray her as nothing but a sexual being is equally to oppress her"*

(Greer 1999:410-11).

She discusses Madonna and Courtney Love as being part of this group, seen as hard drinking, randy young females who are now becoming younger as they become older; in fact she describes them as now emerging in their pre-teens. The airbrushing photographs to emulate younger celebrities is now commonplace.

Haraway's (1997) writing is on the cusp of the third wave, overlapping with postmodernism and arguably drawing feminists into new ways of thinking. Haraway (1997) found ways of meaning for technologies as a whole, including that of cyberspace. She introduced cyberfeminism along with Plant (1995) as a new way of seeing. Cyberfeminism is a woman-centred perspective that advocates women's use of new information and communication technologies for empowerment (Miller 1998). Hawthorne and Klein (1999) claim that cyberfeminism is a philosophy that acknowledges that there is a difference between men and women, specifically in the digital discourse, but more importantly that cyberfeminists want to change it. Because they want to change

the world, this sets them away from post feminism, even though it is sometimes described as such. Their political acumen puts them into recognition of third wave feminism, even though they may resist the labelling. In her research on social interaction online Kira Hall (1996) found that rather than neutralising gender, the electronic medium encourages its intensification. In the absence of the physical, network users exaggerate societal notions of femininity and masculinity in an attempt to gender themselves. This blows the argument of cyberspace allowing non-identification of gender out of the water and suggests gender runs much deeper within our unconscious, moulded expectations of gender within society.

By third wave feminists opening up feminist thought to new possibilities this has influenced the thinking around my study. At present I am still unsure which feminist theory to use at this stage. I will use the findings from the background and literature review to guide the first phase of this research study. I will then revisit feminism in relation to the results.

### **3.3 ETHICAL CONSIDERATIONS**

This part of the chapter discusses the ethical considerations of the first phase of this study, which will then lead to the research design for this phase.

#### **3.3.1 Harm**

Recognition of doing harm to participants is necessary throughout the data collection process. This research process would not cause any physical harm, but may cause psychological harm. Awareness of women being upset or distressed when recalling their childbirth experiences was an important aspect of this process for me. I decided to use a semi-structured interview schedule to allow women to choose themselves if they wanted to discuss aspects that may distress them. I was aware of professionals and groups that I could refer any of the participants to if I felt they needed further help to deal with their experiences, Cribb (2003) acknowledges this as an important consideration in the research process. A rigid schedule may have forced them into answering questions that they felt uncomfortable with. I ensured that my approach to the focus groups discussion was open, friendly and confidential, to allow the participants to build up an element of trust with me.



### **3.3.2 Consent**

Clear written and verbal information on the nature and purpose of the study is essential to ensure participants understand what the study will entail for them (Manning 2004). It is also important that the researcher ensures the information is in a form that participants can understand. Translation needs to be considered depending on the demographic information of the population that the sample will be extracted from. Within the population for the focus group samples the majority of the population are geographically static within the area, they are white and they are generally from vulnerable groups, as the Index of Multiple Deprivation (IMD) Quintile is identified at 4 and 5. Due to the increased likelihood of the participants suffering deprivation there is a risk of increased vulnerability of the sample. It was therefore essential that any information was easy to read and that all information was verbally discussed to ensure participants with poor reading and writing skills understood what participating in the study would involve.

Consent was gained by the hospital trust and from the research ethical committee for the study to go ahead. I met with all of the community midwives two weeks before this phase of the study commenced to discuss the study and their role in identifying potential participants for the purposive samples I had chosen. I gave them written information to refer to, regarding the sample required. The community midwives then selected and gave written information to potential participants about the study. The women contacted myself, as the researcher directly if they decided to participate. The community midwives discussed the study with potential participants and answered any questions that they had. I informed the community midwives when 10 women for each focus group had contacted me. I had therefore reached saturation of the sample.

At the focus group locations all of the women were given another information leaflet on attendance to the group and given time to read it. I ensured they had read and understood the information leaflet they had been given and answered any further questions prior to them signing the consent form. I obtained consent from the participants thirty minutes before recording commenced. Reinforcing the information at different stages of the process would help to ensure they are comfortable with the implications of taking part in the study. Consent was not

only signed to participate in the study, but a second consent form had to be completed for the use of quotations obtained and used in research reports, as specified by the research ethic's committee.

### **3.3.3 Confidentiality**

Due to the small sample size the participants are at a greater risk of being identified, therefore confidentiality is important to obtain anonymity and confidence of trustworthiness within the group. Murphy et al (1998) discuss how confidentiality is at a high risk of being breached during publication and dissemination of the research findings. The use of pseudonyms was used throughout this study to protect their confidentiality within the process of analysis. The participants could choose one or were allocated one by myself, as the researcher. I reimbursed travel expenses to the participants who attended the groups. At the beginning of the focus groups the importance of confidentiality was discussed, all of the participants agreed to keep the discussions within the focus groups as confidential and not divulge any identification of participants. The focus groups were recorded using audiotape. The tape was transcribed verbatim by myself as soon as possible following the focus groups to assist recall. It was made clear in the information and verbally that they were able to withdraw from the study at any time and that this would not affect the care they were receiving. Data was kept within a locked cabinet on NHS premises. To protect participant confidentiality all data were stored and collected by myself.

### **3.3.4 Ethical Committee Experience**

Many British ethics committees until recently (Department of Health 2001) have not had any members with qualitative research expertise. Ethics committees have been stuck within a realist's objective pursuit of truth and validity, but are now required to show understanding of different types and styles of research. The process has changed over my time on this journey; therefore my experiences in the first phase were different to those experienced in the second phase of this research study. My study became considerably delayed, as I had to endure application to the Ethics Committee on two occasions for the first phase. My experience is discussed in Appendix 4.

### **3.4 Research Design**

I used the knowledge gained from the literature review and background to guide my design. The construction of the first phase of this study is now discussed. I decided, following consultation with my supervisory team, that I would use an interpretive design using a thematic approach for the first phase of this study, to allow the findings from it to guide me to my theoretical perspective.

#### **3.4.1 Sample**

From the literature review it appears evident that women receive care differently within different models of care, led by different professionals, this area requires further exploration. An element that was not clear within the literature was if there would be a difference in perceptions if women had experienced the maternity services previously, or if this was their first experience. Another interesting aspect would be to compare women who are pregnant and those who have recently given birth. Therefore, a purposive sample was chosen to guide these elements. Purposive sampling is about seeking out groups or individuals where the processes studied are likely to occur (Morgan 2003). Ten women made contact with me for each of the four focus groups, who wished to be included in the study. I contacted the women the day before the focus group to remind them. Some had changed their mind about attending and others did not attend on the day. The groups were therefore small in size, varying from 2 to 3 participants in each. In qualitative research the aim is to seek out experiences of individuals in relation to a phenomenon. A small group size allows in-depth data to be collected, if they are drawn from a purposive sample this can be 2-4 participants (Morgan 2003). It is especially meaningful if the sample is purposive, as the participants generally may have 'common ground', making it easier to explore certain aspects relating to that particular group of individuals.

### 3.4.2 Recruitment

The sample for the first phase was recruited from a Hospital Trust that provides three different birth environments. These were the woman's home, a midwifery led unit and a consultant led labour ward. Within each of the four groups, eight women were recruited. Women within the purposive sample were given information leaflets by the community midwives and asked by them if they would like to participate. The community midwives gave me contact details of the women who wished to participate. I contacted the women by phone at least 2 days after they had been given the information leaflet. If they agreed to participate their name, phone number, parity and lead professional details were recorded; I then placed them in the appropriate sample. They were invited to a focus group following invitation by a further telephone call. Three of the focus groups were held at the Hospital, one was held at a local Health Centre.

Three women attended the midwifery-led care postnatal group. Two women attended each of the other three groups, these were: the consultant led care postnatal group; the multigravida (multip) antenatal care group; and the antenatal primigravida (primip) group. This allowed for similar women with shared experiences to be grouped together.

See figure 3.1 below for details about participants in phase one.

**Figure 3.1 Phase One Participants**

<b>Focus Group</b>	<b>Pseudonyms</b>
1) Women 6 weeks following birth of baby (P/N) Receiving midwifery led care (MLC) Birth in Midwifery Led Setting	Louise Sarah Liz
2) Women in at least their second pregnancy (A/N, Multip). (Incidentally receiving consultant led care)	Shona Carol
3) Women in their first pregnancy (A/N, Primip) (Incidentally receiving consultant led care)	Susan Tara
4) Women 6 weeks following birth of baby (P/N) Receiving consultant led care (CLC) Birth in a consultant led setting	Jane Debbie

### **3.4.3 Reflexivity**

Using a reflexive approach within qualitative research is an acceptable method of acknowledging 'self-awareness' in the research process (Kingdon 2005). Ramazanoglu and Holland (2009) discuss how reflexivity is valued as critical reflection at different levels, of which they include:

*"Identification of the exercise of power, power relationships and their effect on the research process...and the ethical judgements that frame the research and mark the limits of shared values and political interests"*

(Ramazanoglu and Holland 2009:119).

It is important for the researcher to acknowledge their values and beliefs, so that self-awareness is gained of how this may affect the research. This approach demands awareness and requires appropriate responses between the researcher and participants of the research. During this first phase, I did feel that I acknowledged my self-awareness and tried to 'bracket' myself off to some extent, as I was so aware that I may have some influence on the process. By stating who I am and where I 'come from', I aim to be 'up front' about my values and beliefs, allowing others to recognise my aim to reduce any bias within this study. I now will 'lay down my baggage'.

### **3.4.4 The Start of my Journey**

I have been a midwife since 1991; prior to that I was an enrolled nurse and then a registered nurse. I always struggled with the 'handmaiden' tag associated with nursing and reached out to the autonomy and opportunities I thought midwifery could offer me. Throughout my midwifery career I have had a strong belief that normality in childbirth is to be treasured and celebrated. During the early years of being a midwife I became increasingly frustrated with the dominance of medicalisation on the childbirth process. All research projects were related to testing out machinery or drugs and the only research conducted was quantitative; the objective was about furthering knowledge within a realist framework to support the mechanics and medicalised perspective of birth. Having worked throughout all areas within the hospital, I became disillusioned within this world and longed to give women the experience of birth I felt they should have. A world where they were in control and labour could find its own rhythms. Birth is something a woman has achieved herself, not something the

midwife or doctor has performed to 'deliver' the baby. Community midwifery and working within the midwifery led unit gave me the experience to reaffirm my faith in normality. I went on to lead the midwifery led unit and then develop and expand it, at a time when the institution wanted to close it. This provided more women the experience of normality (Cooper 2004).

I am now a consultant midwife in normality for a different hospital trust. I have tried tirelessly to develop midwifery led environments, but this proves to be a lengthy task. The women and local childbirth groups have been extremely supportive and they maintain my strength to achieve this for them. The influence of medicalisation and technocratic birth is dominant on the labour wards. On my own to change this culture feels an impossible task; only by working together as a team can change occur. At present I feel women are not given the opportunity to experience labour and birth in a normality focussed environment and culture and I feel sad and helpless that I am not achieving this for them. We do have plans for a midwifery led unit, but currently have no commitment of a time frame.

I really want to make a difference to women in the maternity service and want their voices to be heard, along with midwives. Producing this research study is my way of stamping my commitment to normal birth philosophy and improve the service women and their families receive from the NHS. While also, increasing job satisfaction for midwives in the workplace.

#### **3.4.5 Method**

Focus groups were chosen as a method to provide a baseline of women's perceptions and allow for exploration of the areas identified. Insights into beliefs and attitudes of the underlying behaviour of a specific population can be achieved by using focus groups (Carey 1994; Asbury 1995). Ground rules around confidentiality and respecting each other's voices and opinions were discussed at the beginning of each focus group. Walsh and Baker (2004) discuss how facilitating focus groups can be a specialised task as some participant's viewpoint and voice can overshadow others. It is therefore important that the group is facilitated fairly, allowing everyone to contribute.

I chose to use a semi-structured interview approach to allow for some flexibility, to protect the participants from disclosing aspects they felt uncomfortable with, but also to allow me to change direction depending on the discussion unfolding within the groups.

The purpose of the focus groups was to provide an interview schedule for in-depth interviews in the second phase. Focus groups comprised of 4 groups: 2 primigravid women in the ante-natal period (20-24 weeks gestation) of pregnancy; 2 multigravid women in the ante-natal period (20-24 weeks gestation) of pregnancy; 3 women in the post-natal period (6 weeks) who received midwifery led care and gave birth on the midwife led unit or at home; 2 women in the post-natal period (6 weeks) who received consultant care and delivered on central delivery suite. These focus groups were performed in the north of the West Midlands region.

The focus groups were audio recorded with the agreement of the participants. A semi-structured interview plan was used, which had been agreed by the Ethic's Committee. Field notes were made following the discussions. The field notes included the reactions of the women when discussing certain issues.

#### **3.4.6 Aim**

The focus groups aimed to provide answers to:

- a) What women know about the midwives role.
- b) How women think the midwives' role relates to that of other health professionals.
- c) What external factors are contributing to women's perceptions of the midwives' role?
- d) Do women's perceptions of the midwives' role influence their choice of birth setting?
- e) Do women's perceptions of the midwives' role influence their clinical choices?
- f) What role do women want midwives to play in maternity care?

### **3.4.7 Moderation**

A member of my supervisory team (CK) agreed to be a moderator for my focus groups, to help prevent bias of my own values and beliefs within the discussions. She also assisted me with field notes. Members of my team listened to my transcriptions before coding and thematic analysis was performed, also with their guidance. Following thematic analysis we discussed the data in relation to generation of the themes, to ensure my own biases were not influencing the themes generated.

### **3.4.8 Analysis of the Data**

I initially sat and listened to the data recordings three times, before attempting to transcribe any of it. This made me familiar with it, so that I could interpret how they were feeling and relate this to my field notes. Members of my supervisory team listened to the tapes and then I transcribed the data myself. I moved on to set the task of breaking the data down. I decided not to use any computer software, but to do this manually, as I thought that this would allow me to become immersed in the data and absorb real understanding of the responses. I read and reread the transcripts, coding words that were reoccurring line by line. When I had coded the words I grouped them into themes. I did this process one at a time through each focus group. I found this experience extremely valuable, as I felt that I knew my data 'inside out'. At a few points there were notes joining up codes and codes crossing over into other focus groups, therefore at times it was difficult keeping track.<sup>18</sup>

Collective analysis of the completed transcripts was carried out, this identified four main themes: empowerment of women by midwives; influence of media, family and friends; technology and monitoring; influence of doctors. These will be discussed in Chapter 5.

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<sup>18</sup> Examples of analysis from the focus groups are included in Appendix 5.



### **3.4.9 Member Checking**

Carter (2004) discusses how member checking can be used to confirm the interpretation of researchers. I decided to use this to increase the credibility of my study. When the transcriptions were complete I posted each participant a copy of the focus group transcript they participated in with my contact details if they felt the transcript was not a true reflection of what they had said. I received no contact from any of the participants. I did arrange an afternoon following thematic analysis to feed back the findings to the focus group participants and the community midwives six months after the focus groups had been performed. I reimbursed travel expenses to the participants for their attendance. The six participants who attended appreciated this feedback and they were all given a written copy of the findings.

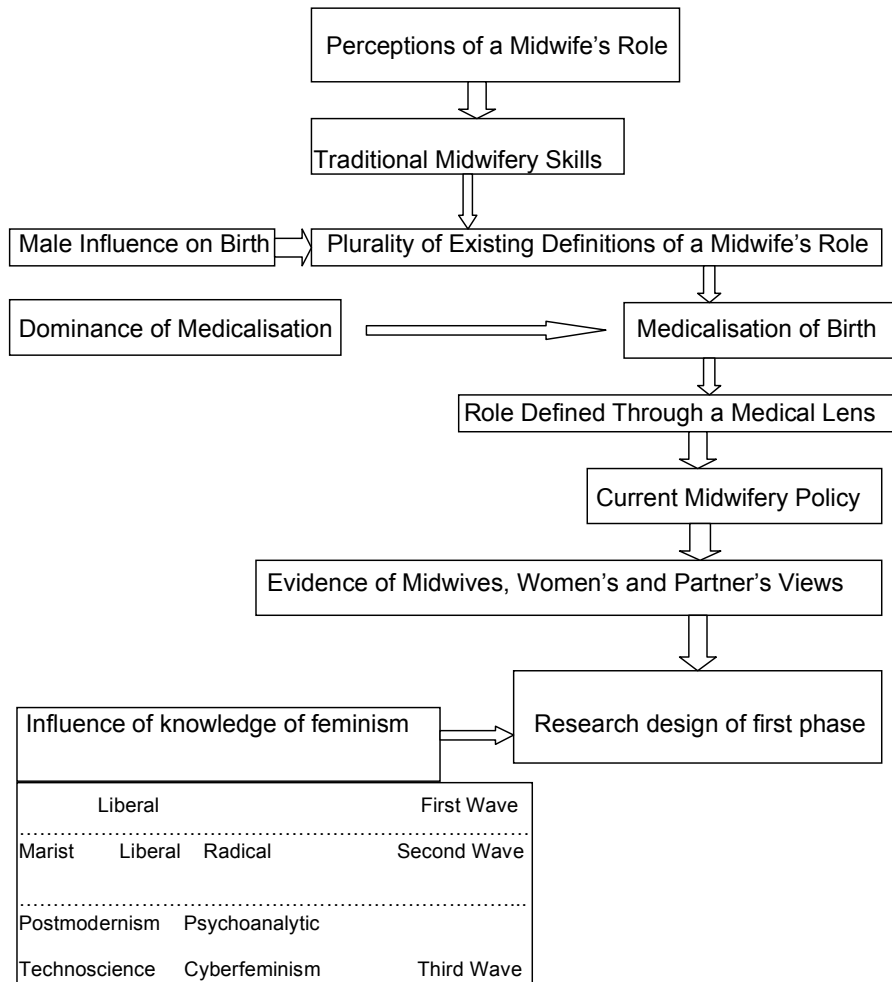
### **3.5 CONCLUSION**

This chapter provides the methodology in relation to the first phase of this research study. This first phase methodology provides a framework to investigate women's perceptions of a midwife's role, using the knowledge gained in the background and literature review.

My journey through the various branches of feminism is analogous to taking layers of a prize in a "pass the parcel" game; each layer offering insight into the relationship between feminism and my study. It feels like a long journey, but a worthwhile one with lots of adventures experienced along the way. This provides the basis for further advancement towards a chosen theoretical perspective, which will be explored in the next chapter. Chapter 4 discusses the methodology for the second phase of this study.

Figure 3.2 below demonstrates my research journey so far.

**Figure 3.2 Research Journey**



## CHAPTER 4

### METHODOLOGY: THE SECOND PHASE

#### 4.1 INTRODUCTION

The link between the study and feminist theory is an important one as it looks at the responses of the women through a lateral lens, bringing out issues that would not have been considered at face value. I have found it difficult to relate just one type of feminist theory at this point of my research journey. My decision is to identify the themes generated from the first phase of the study and use these to inform my choice of feminist perspective.

I felt it to be more appropriate to put the two findings chapters together, so although the findings of the first phase have influenced the methodology in this second phase, I still feel that it is more appropriate to keep the two methodology chapters together<sup>19</sup>. The methodology for the second stage is discussed in this chapter.

This thesis principally relates to midwifery practice; however it also draws from and aspires to make a contribution to feminist theory. This chapter identifies my chosen theoretical perspective underpinning this study. This follows an exploration of the role of the midwife in relation to feminist theory and interpretations of the midwife's role and of childbirth through the lens of the media, where social perceptions may be created.

As my main theoretical contribution I have decided to draw on Haraway (1988, 1991, 1997). I justify why her work is important to the understanding of the perceptions of women and midwives related to the midwife's role. Feminist theory has offered me the opportunity to look at my findings from a different perspective, giving the women's voices an opportunity to be heard through a real world microphone. My chosen methodology is aligned with a postmodern feminist technoscience theoretical stance. This chapter will discuss the considerations of epistemology and my ontological position. I will discuss my

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<sup>19</sup> Please refer to chapter 5 for further information relating to the findings of the first phase of this study.

chosen theoretical perspective drawing on Haraway (1988, 1991,1997) and relate her concepts to the methodology. The use of an organisational thematic analysis tool is also discussed, particularly in relation to how it is used to enhance my ability to capture the voices in the study. The tool was developed to assist analysis in feminist work (Attride-Stirling 1998) and its use in this study ensures that when organising the different types of data, the voices are not lost within the analytic process. Claims of truth and validity will be discussed in relation to feminist research and how I intend to address this in the second part of the study.

This study is unique in its nature as the women's perceptions of the midwife's role are reflected with those of the midwife who were present at the birth. This provides a mixed methods approach using different sources of data from women and midwives, relating to perceptions of the midwife's role. This chapter discusses Haraway's (1988, 1991, 1997) concepts. A clear strategy and plan of action is presented to explore women's and midwife's perceptions of the role of a midwife. This has ensured a pivotal collection of data, by using a mixture of methods.

#### **4.2 FEMINIST THEORIES AND THE ROLE OF THE MIDWIFE**

This section centres on feminism in relation to the role of the midwife. The history of feminist thought relating to childbirth can be traced back to 'witchcraft' in the middle ages. Ehrenreich and English (1973) describe how women would discuss and educate women about the physiology of sexual intercourse, discussing sexuality openly. The medieval Catholic Church labelled these women as witches. The church associated women with sex and all pleasure in sex was condemned as it was thought to be associated with the devil. Women also used herbs and potions for healing; these women too were labelled as witches. Witch healers were usually the only access to any kind of medicine, as there were no doctors or hospitals available to them. There was usually a physician available to the kings, nobles and upper classes as he was not only male but also a priest, therefore this was acceptable as it was under the control of the church, female healing as part of a peasant culture was not.

Two witch hunters described in Ehrenreich and English (1973) discuss the strong association of the witch and the midwife and state:

*"No one does more harm to the catholic church than midwives"*  
(Ehrenreich and English 1973:3).

Perhaps the church felt they were unable to perform the role of the midwife and felt threatened by this, therefore, they were unable to control them. Many of these women met as large groups, which are now thought to be pagan religious festivals, where they would share their information and was thought to be part of the peasant rebellion of the time. Witches offences were seen as crimes to men, therefore they were often tortured and condemned to death by the church.

Ehrenreich and English (1973) then go on to discuss the advent of medical men and medical schools in the 1800s, which kept the majority of women out. Therefore, the only route for women into medicine was nursing. Nurses at the time of Ehrenreich and English's writing in 1973 were taught not to question and not to challenge:

*"Our subservience is reinforced by our ignorance, and our ignorance is enforced"*  
(Ehrenreich and English 1973:4).

They used a picture of 'wonder woman' wielding a speculum around men in white coats, three of them lying on the floor, with only one standing. The caption from 'wonder woman' read:

*"With my speculum I am strong, I will fight"*  
(Enreich and English 1973:5).

Haraway (1997) revisits this issue, describing the speculum as becoming a symbol of the displacement of the female midwife by the specialist male physician and gynaecologist. She argues that it is also a sign that women collectively have joined together through the Women's Liberation Movement to declare that:

*"We have discovered ourselves and claim the new territory for women... the repossessed speculum, sign of the Women's Liberation Movement's attention to material instruments in science and technology, was understood to be a self-defining technology"*  
(Haraway 1997:193).

Taking the instruments from men and wielding these against them proved to be a threat to the obstetric community, so the men (obstetricians) chose to take the

instruments back from the women (midwives). Midwifery was blasted out of significance in America by an enforced effort of the obstetricians to discredit the midwives by using the argument that they had caused uterine infections and neonatal ophthalmia, which could easily have been treated. Therefore, midwives were no longer able to practice in America, even though the cases of the above conditions continued to rise. Fortunately this was not the case in Europe as midwives continued to practice.

Medicalisation continued to impact on normal childbirth. Rothman (1982) describes how obstetricians have increased their control over women through the maternity services by using a process of medicalisation. In 'From Here to Maternity' (1980) Ann Oakley describes how childbirth is a human life event and how medicine is a controlling institution. These two authors were the first to acknowledge the power of medicalisation on women during their experience of childbirth. Later on Oakley goes on to give a detailed historical account in the 'Captured Womb' (1986) of medicalisation on childbirth. She puts forward the proposal that there were two stages to its uptake. Firstly in the eighteenth century pregnancy was thought to be 'natural' and 'normal', when medical practitioners upheld a paradigm of pregnancy that appealed to:

*"Nature as the arbiter of its proper management"*  
(Oakley 1986:12).

She suggests that advice and information given to women was not distinguished from obstetric knowledge. But, by systematising women's experiences the medical practitioner appropriated knowledge of pregnancy and began to redefine it as technical and medical expert knowledge. This developed into pregnancy being viewed as pathological and became increasingly controlled by the state and health professionals. The health professionals were then viewed as those possessing the expert knowledge. Knowledge possessed by the woman herself was the last rung on the bottom of the ladder. Medical knowledge was viewed as unquestionable and an absolute certainty of truth, but this was not based on any evidence and was merely socially produced. Jordan (1997) and Davis-Floyd (1997) discuss authoritative knowledge and its influences within childbirth. This rise in medicalisation was linked with developments of modern capitalist societies (Turner 1995). Davis- Floyd (1992)

discusses how the influence of capitalism led to technocratic birth<sup>20</sup>. Oakley sketches out the history of medical technologies used in obstetrics including: in 1882 caesarean sections were performed in Germany; in the 1930s three popular methods of inducing labour were in use, which were ARM (artificial rupture of membranes), drug therapy, and mechanical dilatation of cervix, though techniques for inducing labour date back to the nineteenth century. Also at this time forceps and episiotomy became routine procedure for breech delivery in the UK; 1957 first ultrasound of a pregnant woman, ultrasound screening becomes routine in 1970s; 1960s Electro-fetal monitoring during labour; 1978 Amniocentesis screening test developed and the first IVF baby (Louise Brown) born. These are approximate dates, according to Oakley, the origins of these often predate when obstetricians claim to have discovered them.

These surveillance techniques and obstetrical practices increased the scope of influence and control obstetricians had on women. It also created the opportunity of seeing the fetus as a separate entity from the woman. Haraway (1997) discusses how expectant mothers emotionally bond with their fetuses through learning to see the developing child on screen during a sonogram. Women lose the ability to connect with the unborn child without the use of technological means.

*"The bonding produced by computer-mediated visualization also produces subjects and selves; the touch at the keyboard is generative- emotionally, materially, and epistemologically"*  
(Haraway 1997:177).

Martin (2001) discusses how one of the women in her study describes how she was not able to see, feel or hear her baby's heartbeat herself, that she relied on the doctor to allow her to hear it with the sonic aid. She felt that she had to rely on the doctor to do that for her; therefore she relied on him and the machine to put her in touch with her baby to feel any union between them. There is also a link here with where obstetrics was derived from. Obstetrics is concerned with women's bodies. It branches off from medicine, which is concerned with the treatment of bodies. Therefore, the belief from medical practitioners is that the

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<sup>20</sup> Described in Chapter 2 Technocratic Birth in Relation to the Role of the Midwife, section 2.2.5.6

female body in pregnancy should be treated, which does not fit with the 'natural' and 'normal' physiological origins of childbirth.

Martin (2001) describes how the body is viewed as a machine to medical doctors, which has to be organised and managed. Technology is used to control the body, so that it is orderly and tidied up.

*"When medical doctors describe the labour that women do in childbirth, their expectations centre on how labour of other kinds is organised in our society and how technology and machinery can be used to control those who labour"* (Martin 2001:66).

She describes how medical knowledge about menstruation, birth and the menopause is constructed as a hierarchical system of centralised control organised for efficient production and speed (Martin 2001). These processes of life are viewed as a breakdown of the machine, which needs to be repaired by medical doctors. Lack of care or interest is given to the emotional and psychological part of the body, as this is unable to be broken down into parts and systems. It therefore, is unable to be managed so is ignored. Martin's study (2001) asks women how they 'come to know' (Kingdon 2007) from their own bodily processes and discovers how women juxtapose biology and culture to conform to the social order they are within. Her point is that the women know that there are different worlds and use this knowledge to their own advantage. For example, Martin (2001) describes how women resisted medical management of birth by delaying accessing the hospital until they were sure themselves that labour was progressing by listening to their own body. They understood that the earlier they were admitted; the sooner labour would be defined as ineffective. Cussins (1998) discusses how women have different views of technology and intervention, moving between the two stances.

Davis-Floyd (1994) found women had opted for either a technocratic or a natural birth. Therefore, what we view as a relinquishing of a woman's body to the medical model in a feminist standpoint theory perspective may actually be the woman's choice and this is how she achieves empowerment for herself. She views them both as seeking empowerment, but using different means to achieve it. Haraway (1991) discusses how women use technology to their own



advantage<sup>21</sup>, she describes a cartoon drawing by Kelly (1992) which shows a woman lying naked on a bed with her face turned towards a computer screen. On the screen is a fetus; the woman has her finger touching the keyboard. She states:

*"The fetus is her file, which she is writing; editing; or as one viewer suggested, deleting...maybe she is reaching for the 'escape' key or perhaps merely the 'control' key"*  
(Haraway 1997:186).

The world of technoscience provides a way of understanding worldly material-semiotic practices like the one described above<sup>22</sup>.

Medical research was concerned with scientific measurement and did not take into account social and emotional aspects of their subjects. This was due to the mechanistic view of the body and the authoritative knowledge being held within medicine. Because of the patriarchal structure within the hospital institution, doctors supported each other's proposals of research within the dominant culture, so that their view of the world became supported by evidence. Quantitative research is concerned with hygienic, statistical mathematic processes. Subjectivity is ignored and the body seen as an object of analysis, rather than a thinking, feeling human being (Kent 2000). Qualitative research used by sociologists captured lived experiences in the late 1970s through the use of the survey, which then led to structured interviewing but these had their difficulties. Oakley (1981) recognises that the paradigms of traditional interviewing practice creates problems for feminist interviewers whose primary orientation is towards the validation of women's subjective experiences as women and as people, and illustrates the lack of fit between theory and practice in this area. But, women's stories were now beginning to be heard.

Foucault (1973) described how the use of a clinic could capture pregnant women to be used for the practice of obstetric techniques that increasingly became dependant on large amounts of capital expenditure for high tech

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<sup>21</sup> This is also described raising a different point later in this chapter 'Understanding perception's of a midwife's role: How can Haraway help?' in section 4.5.

<sup>22</sup> See section later in this chapter 'Understanding perception's of a midwife's role: How can Haraway help?' in section 4.5.

equipment. Declerq et al (1997) argue that the building of hospitals was not only the purpose of bringing birth into centralised settings, but this development had an overwhelming influence on the location where birth took place. This then provided an economic incentive for governments and the private sector (America) to centralise maternity care, which also satisfied a growing demand for hospitalisation of birth. They also conclude that all of the changes that happened were governed by the financing, which was done as general changes across all aspects of health; there was no attempt to alter the treatment of pregnancy and birth. Independence of practice for midwives is seen in The Netherlands where homebirth continues to be the main birthplace choice for women. Declerq et al (2001) acknowledge that in America, where homebirth disappeared first, the campaign against midwives was an essential part of the hospitalisation of birth and that the ability of midwives and mothers to shape practice is more limited in large hospitals than in homes and small community hospitals and a cultural setting which supports midwives is more likely to support homebirth.

Changing Childbirth (DOH 1993) was a key document in the UK, as it aimed to bring about reform following the disclosures of: impersonal care; lack of continuity; long waiting times; and unnecessary use of interventions from research on women's views (Cartwright 1979 and Oakley 1980). It offered the three 'Cs': continuity of care; choice of care and place of birth; control over their own bodies in pregnancy and birth. This was a real turning point and was viewed as:

*"The integration of feminists interests, the grass roots feelings of women, the heart of midwifery philosophy and practice made possible through government policies"*  
(Annandale and Clarke 1996: 424).

Unfortunately, all of the hopes and dreams of reclamation of normal birth for women and midwives began to dissolve with the realisation that midwives were trying to work differently but the models were based on the midwife being un-gendered, not having family responsibilities and unable to be devoted to women twenty four hours a day. Therefore, there were high levels of burnout (Sandall 1998). The benefits were that the schemes achieved high levels of demedicalised care and maternal satisfaction (Green et al 1998), but the

schemes folded due to lack of funding and to the high levels of burnout being experienced by the midwives. Wrede et al (2001) sum this up:

*“It appears that the midwifery profession missed the opportunity to develop new paradigms of professional practice that incorporates a partnership with users and acknowledge the needs of both providers and clients”*  
(Wrede et al 2001:34).

This can be explained by the new schemes and models of care being built on foundations of an already accepted model within the hospitals of a task orientated, assembly production line way of working, during a time where there were calls for cost containment. These variables made it impossible for the schemes to survive.

The Fordism and Taylorism model are described in Chapter 1<sup>23</sup>. I argue that elements of these models are colluding to offer poor experiences for women in pregnancy and birth and for midwives working within this type of culture. Ball et al (2003) characterises these ways of working as producing disenchantment to the workforce. Hunt and Symonds (1995) describe Fordism and Taylorism as ‘Delivery Suite’ characteristics. The women in research conducted by Walsh (2007) described their previous experiences of birthing on the ‘Delivery Suite’ as being on a conveyer belt and the hospital as a factory. Interception of technology into the natural world of labour and birth has been acknowledged above. The advent of prenatal testing creates an overwhelming complicated technological view of pregnancy and childbirth for women, far removed from the ‘natural’ and ‘normal’ physiological process it is. Technology and testing create a camouflage for the truth underneath. It creates an invisible cloak of technology and complication, which prevents women from enjoying their pregnancy and the natural feeling of excitement as the baby grows over the course of pregnancy. Instead women are worrying about the results of testing and how and when they are going to get to their next antenatal clinic appointment, rather than having a massage or a relaxing bath. But other women view this as advancement and want the testing for reassurance, even though much of prenatal testing is flawed with false positives, which can create unnecessary stress for women, partners and families. The tests also do not generally lead to a treatment. The only choices offered are the selective

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<sup>23</sup> See chapter 2, section 2.2.5.6 The Emergence of Technocratic Birth.

abortion of an affected fetus or maintaining the pregnancy knowing the condition of the fetus and the prognosis of the child it might become (Rothman 2001).

Other work on reproduction has acknowledged that women may gain benefit from technology and intervention or see the potential for abuse from it.<sup>24</sup> Jordan (1993) investigates the theory of authoritative knowledge and how this changes depending on the cultural perspectives within the environment experienced and how this impacts on the experience of birth for women. The authoritative knowledge within a hospital environment is often that of those in senior hierarchical positions within the institution. More often than not these positions are ring fenced for medical doctors, for example, the role of clinical director. The medical doctors within a hospital environment generally conform to the same beliefs; some are very supportive of normal childbirth and midwifery practice, while others are not and may fully support medicalisation of childbirth. The knowledge belief system that is dominant becomes of a greater influence than any other belief system. The woman and other health professional may not have the same belief system, so they conform to the authoritative one. If this is predominantly supportive of medicalisation then those who do not conform may lose their job or become disillusioned and look for an alternative career or an alternative environment to give birth in. Other belief systems become over powered, therefore become unheard. The authoritative knowledge then becomes more powerful as it weaves its way into politics and law, stifling any other beliefs.

Spallone (1989) argues that power relations between inventors and users of technologies are not liberating for women. Her view is that women are required as exchange body parts for 'progress'. I believe it to be more complicated than that, as already indicated<sup>7</sup>.

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<sup>24</sup> See earlier point made by Davis-Floyd (1994), Martin (1991) and Haraway (1997) in section 4.2.

<sup>25</sup> See earlier point made by Davis-Floyd (1994), Martin (1991) and Haraway (1997) in section 4.2.

### 4.3 WOMEN AND INTERPRETATIONS OF THE MEDIA

Many American television series come under criticism including 'The Practice', 'Law and Order', 'ER', 'The West Wing' and 'Ali Mc Beal' all provide idealism of what reality actually is. The characters if female are white upper middle class, the men are hunky actors all involved with love stories and suggesting women need a man to be part of their life to be happy and content. The majority of women are portrayed as successful businesswomen, the men are generally white and the world is viewed from these perspectives.

*"Television's incessant repetition of reductive images of women- as sexually objectified or "marriage material", as "incomplete" without heterosexual romantic fulfilment, as dumb, flaky, vulnerable, insignificant or other- has a psychological impact on women that is not necessarily reflected in whether they vote, go to college, or own a business. The bottom line of television programming is corporate profitability; as long as the networks, cable stations and internet are all controlled by large conglomerate interests, one can expect only the most homogenised values to be represented, ones that underwrite, however disguised the mechanism may be, the ideology of white, male power"*  
(Mintz 2003:77).

Programmes forming a new direction, for example, 'Buffy the vampire slayer' on the other hand is seen as a bit of a super third wave feminist hero. This show represents a move away from the male centred superhero narrative. The characters in the show represent strong vibrant young women. They represent a spectrum of possibilities for contemporary womanhood, which includes super intelligence, physical strength, the desire for relationship, the quest for independence and the refusal to be dominated. Fudge (1999) recognises that Buffy has the edge, which appeals to the daughters of the second wave. The viewing figures were high for such a small network, showing its popularity especially with the young adult market. This suggests change may come or may become stifled by big television networks and their current choices of production.

#### 4.4 BODIES AND IMAGERY OF BIRTH

One source of information to women about the midwife's role is the media (Clement 1997). Many magazines relate to childbirth stories or issues in pregnancy and birth, some are based solely on parenting and pregnancy. Many of these magazines base their photographs on the image of the 'Madonna', resting her hands on her abdomen showing concern for her baby, looking down at her abdomen expectantly or her head tilted slightly towards the camera. Through these images of pregnancy the woman is defined as a 'real' woman and expected to find motherhood as a rewarding and enjoyable experience (Kent 2004). Williams and Fahy (2004) looked at how women had been influenced by women's magazines in Australia. They found that women viewed them as authoritative knowledge and were a primary source of information. They found that the interests of medicine were well supported, women viewed ventouse extraction as virtually a normal birth, categorising intervention as a normal physiological process. One of the women was portrayed as a role model for others whose compliance with medical 'orders' promised a pain free birth and a healthy baby, signifying the cultural promotion of the idea that medicine should be in control of normal childbearing.

How women view images of birth and pregnancy may colour their own expectations of childbirth. As discussed above the media can be an influential source of knowledge for women so it is important to find out if this knowledge has had any effect on how they perceive the role of the midwife. Betterton (1996) suggests that the Benetton advertisement showed the newborn baby apparently still attached to its mother, with the cord still appearing attached to her. This vision was thought to be controversial. It destroyed the accepted view of individual bodies being separate from each other. Bodies in the media are perceived as being disembodied.

Betterton says:

*"The image represented Kristeva's (1982) idea of the horrific by collapsing the border between inside and outside, self and other, unsettling bodily boundaries and threatening identity"*  
(Betterton 1996:80).

I can relate to this viewpoint, but I view it as a beautiful image the mother and baby being attached to each other has a visual power of commitment and

support to each other, which will never be broken. The baby being fresh from birth challenges the normal imagery seen.

The photograph of Demi Moore in *Vanity Fair* in 1992, where she was nude and pregnant challenged socially constructed notions of how pregnant women's bodies should be portrayed. This challenged the 'Madonna' picture ideal as it viewed the pregnant body in a sexual way, having pride in her pregnant body (Stewart 2004).

Birth in television programmes usually emphasises a rush quickly to the hospital at the sign of the first contraction and promotes epidural and caesarean section as being the 'normal experience'. In the majority of situation comedies birth is presented as an emergency, from which, women and babies are only able to be rescued by doctors (Kitzinger 2005).

This conflicts with the autonomous role of the midwife<sup>26</sup> and questions who is informing the programme makers about the role of the midwife. In these programmes if they have a normal birth the baby is usually delivered by a doctor, in reality a midwife is the senior person in the room at 68% of births (RCM 2000). If women view the doctor as delivering their baby as a normal event from the perceptions these programmes project, then they may be surprised or disappointed that it is the midwife who helps facilitate them giving birth.

In 2005 an advert for 'Virgin Trains' asks if there is a doctor on the train for a woman who is about to give birth. They plug in some electronic equipment and a male doctor appears with a newborn baby. This portrays the woman's body as needing to be disciplined by medicine via technology (Britton 1998) and the portrayal of the doctor as the professional able to rescue her (Kitzinger 2005). Childbirth is portrayed in a wide range of television programmes, which allows access to childbirth documentaries on a twenty-four hour basis, many of them being American. Arguably depending on how childbirth is portrayed it will have a significant influence on how the role of the midwife is viewed by various audiences, including the women in this study.

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<sup>26</sup> See section 2.2.6.1, Institutional control in Chapter 2 for definition of autonomy.

Within midwifery journals there are some images of childbirth that capture the unique relationship midwives have with women. Unfortunately there are also plenty of images of midwives looking at technology attached to the woman, rather than the midwife photographed connecting with the woman in a psychological way. This is based on the medical view of childbirth as described earlier, which would influence the readers vision of what a midwife is, therefore influencing midwives. Midwifery philosophy is based on normality and being 'with woman', this imagery is poles apart from where we are supposed to be. Emily Martin (2001) analyses how the uterus is viewed in obstetrical literature and relates it to work seen and measured in industry:

*"What the uterus does is expressed in terms that would be familiar to any student of time and motion studies used in industry to analyse and control workers movements"*  
Martin (2001:58).

Braverman (1974) discusses time and motion studies describing its function as to control the exact movements of a worker, so as to increase production. Martin (2001) suggests that this language is regularly used to discuss contractions in labour within the literature, therefore viewing it as a machine, with the woman as the labourer and the baby is the production. She observes within the literature that it is the doctor who 'manages' the labour process. It is the doctor who makes sure the production line is running efficiently and is producing within its time limits. These interpretations of 'how birth is' then spill over into other literature that others will read. As doctors form a large significant part of the workforce now on our labour wards, these interpretations become embedded by others working within this hierarchical environment, which influences midwifery and women's literature. This then becomes an accepted belief by others as well as those from the medical profession. This is an exact example of how situated knowledges occur, which will be discussed in more detail in the next part of this Chapter.

Weekes (1983) says that doctors have created the attitude that a caesarean delivery implies that a 'perfect' baby will be produced. Hibbard (1976) said that there is a new growing principle:

*"Vaginal delivery only of selected patients"*  
(Hibbard 1976:804).



As described earlier in Chapter 2, the caesarean section rate has seen a rapid increase over the past 15 years, with an insignificant reduction in the number of perinatal mortality cases, compared to the sharp rise in caesarean sections. This shows that caesarean section and instrumental delivery does not improve perinatal mortality and can in fact be harmful (NICE 2007, Kings Fund 2008). This dispels the myth that caesarean section produces a 'perfect' baby. Despite this fact, caesarean delivery is celebrated as the best and safest option within the media. Beech (2000) argues that images used in the media, especially television, are not an accurate interpretation of labour and birth. She says that the media have:

*"Enthusiastically and uncritically supported the idea that caesarean section is a safe, easy option"*  
(Beech 2000:53).

Weaver (2000) reports that representations of vaginal and caesarean birth within the media contributed to fear of childbirth expressed by the women she studied. However, a study investigating women's request for caesarean section by Kingdon (2009) found that women listened to other mother's stories about birth and the majority of women preferred vaginal birth. Kingdon (2009) states:

*"This suggests that how women actually do childbirth today is likely to shape the views of both peers and future generations about vaginal and caesarean birth"*  
(Kingdon 2009:230).

This suggests women do not rely on the media as a sole source for information and are more likely to be influenced by other mothers.

The media can be critical of the normality of natural childbirth and be extremely influential in misrepresenting what has been said. It can discredit the information and also midwives who are critical of medicalisation and technocratic birth within our society. This impacts on the role of the midwife being misrepresented. Walsh's Zepherina Veitch lecture (RCM 2009a) is an example of this. Walsh (2009) discussed the issues of how our views of pain in labour have changed over time. Epidurals are used as a common form of pain relief on the labour ward. Epidurals carry risks (NICE 2007), are highly invasive (MIDIRS 2006) and can interfere with the normal patterns of labour (Anim-Somuah et al 2009). He then went onto discuss how when normal labour and birth is supported, for example, through the birth environment or from one to

one care (Hodnett et al 2009) the pain in childbirth experienced was less. The original intent of his words was to highlight the failure of the maternity services to provide care that is known to lower epidural rates:

*“Fragmented care systems and clinical, austere labour rooms would appear to be risk factors in themselves for greater reliance on pain medication”*

Walsh (2009:1).

Unfortunately his words were taken out of context as the media reported the epidural debate as professionals urging women to accept labour pain (The Observer, 2009, The Times 2009, Grazia 2009). I experienced this myself when as part of the RCM Research and Education Committee in 2008; the committee put a motion forward to urge midwives to think about using alternatives to epidural for pain relief. I woke up on the morning of the debate to find GMTV (2007) having a ‘phone in’ on whether midwives are right to stop women using epidurals! Our motion was not to stop women having epidurals at all, but to use supportive models; environments and alternative pain relief for women, so that they experience less pain (Hodnett et al 2007 and 2009, Sandall et al 2008). It appears the debate has not moved forward.

Caesarean section for birth and epidurals for pain relief are often favoured by celebrities (Daily Mail 2004, 2007). The slogan “too posh to push” has emblazoned women’s magazines:

The Daily Mail (2007) writes:

*“Too posh to push: Pregnant Christina Aguilera opts for a Caesarean.  
The singer ...is expecting her first child... has allegedly decided to go for the operation like many celebrities before her because she is too posh to push  
Not so pushy mum: .... The singer is reportedly keen to avoid the pain of childbirth and has opted to give birth by Caesarean-section”*  
(Daily Mail 2007:6).

This sends out communication to every first time mother that the pain of childbirth is too horrific and inappropriate for a rich celebrity. It says ‘if you want to be rich and successful like me you too have to make this choice!’ There is evidence that women have been satisfied with their caesarean section experiences (Oakley and Richards 1990) but there is also evidence from women that they felt as if they had no control over their body or the situation. They felt as though they were on a ‘crucifix’ or being ‘raped’ when they had a

caesarean section (Martin 2001), but these women are unlikely to be represented within the media, which appears to support technocratic birth. However there is recent evidence that shows that some newspapers are now reporting less favourable aspects of caesarean section (Kingdon 2008). Leap and Anderson (2004) discuss the 'working with pain' paradigm and the experiences of women who had a homebirth. The women participating seemed to enter an altered state of consciousness involving a separation of mind and body, due to a rush of endorphins, which allowed their minds to let go and their bodies to be in control. The midwife was seen as the crucial element to this process as she was familiar, trusted, supportive and unobtrusive, which allowed the woman to separate her mind and remain in control. With this wealth of evidence it is inconprehensible that the media celebrates technology and intervention.

The owners of the media are often big corporate companies who contribute to slowing down change in our society due to holding stereotype ideals, which continue to be persistent throughout their power structures. This is a similar scenario to the hierarchy within hospital institutions making change difficult to achieve. The media has the privilege to decide which voices are heard. They hold the power to continue to maintain the status quo or challenge the dominant order, through messages given through their corporations. Media companies hold the power to make a change.

Dicker and Piepmeier (2003) sum this up by saying:

*"Without accurate, nonbiased news coverage and challenging, creative cultural expression, it is virtually impossible to move public opinion significantly on women's and human rights issues, to activate (or even reach) the citizenry, and to create lasting social change"*  
(Dicker and Piepmeier 2003:37).

A point made more than 20 years ago appears to still be relevant today, which leaves me to question if we have moved on. Oakley and Richards (1990) suggest that a reason for rising caesarean section rates is one of control; an extension of control for clinicians and a loss of control for women. Which leaves me to wonder 'who is pulling the strings' in the media.

We must also acknowledge that birth portrayal within the western world will have an effect on other societies and cultures throughout the rest of the world. Birth here will influence how maternity services are organised in other countries.

Interpreting women's perceptions of a midwife's role will help us to understand if the communication that surrounds us has had an impact on their views. The information from the midwives will also help us to understand if these images and constant communication has influenced interpretation of how they view their role or if they think the media influences women.

#### **4.5 UNDERSTANDING PERCEPTIONS OF THE MIDWIFE'S ROLE: HOW CAN HARAWAY HELP?**

Haraway is distinctly feminist; her work is rooted within socialist/ Marxist feminism, but entwines with technoscience, while advancing her theories into postmodernist thinking. Haraway moves us into the realm of dealing with technoscience now it is here, rather than looking back and rejecting its presence in our world. She gives us a way of understanding its existence and how we function within it, through a postmodern feminist perspective. Haraway conceptualises technoscience as moving away from complicating our theories of experience. She proposes shifting away from dualistic, oppositional thinking, which categorises technology as solely destructive and fragmentary. She advocates that feminists can contest for meaning, as well as other forms of power and pleasure in technologically mediated societies (Haraway 1991). She uses many terms to describe how it exists invisibly in many ways in our societies, which I will discuss within this part of the chapter.

Haraway (1991) uses the cyborg theory as a way of thinking, which transcends the boundaries of humans and machines, enabling creative possibilities for the future where there is no gender and where identities are not unitary. Donna Haraway's cyborg manifesto (1991) reflects on the blurring of humans and technologies, out of which comes new subjectivities and meanings. Cyborg is a cybernetic organism, hybrid of a machine and organism. She discusses the possibilities for women of using different technologies. An argument she explores empirically in 'Modest Witness' by examining the use of obstetric technologies during pregnancy (Haraway 1997). When viewing technology

Haraway does not just see black and white, as if viewing from a grand theory perspective, but she offers a means of understanding the complexity of technology surrounding birth. She offers a different way of viewing women's perceptions of a midwife's role.

She describes syntactics as the grammar of feminism and technoscience, explaining how we use terms and complicated grammar. We have taken this on as natural and normal usage of language as we have moved into the technocommunicative world of the Internet. This type of language is used to make a type of 'club' where the language needs to be understood for us to be able to function or be recognised within it, this leads to alliances and social relationship. Within the hospital and between health professionals obstetrical language is understood in that culture, often excluding the woman and her partner from the conversation, as they do not understand the language and are therefore, socially excluded.

Haraway (1997) argues that brand names can signify genders and give directional signs on maps of power and knowledge, which can then be viewed as property, the one understanding and using the language as having ownership. So much power and ownership conveyed by tiny little marks, such as © and ™. In Haraway's (1997) work *Onco\_mouse* has a ™ signifying that she is owned, demanding ownership through patency. My interpretation is that this can be related to the woman entering the labour ward, when she walks through the door she hands over ownership of herself to the institution where she is patented. Jordan (1997) discusses how women become devalued through the use of authoritative knowledge within a hospital institution. Non-medical knowledge is not valued within this setting.

*Onco\_mouse*™ is the mouse used for genetic research in the search for a cure for breast cancer. This mouse is the product of many other mice that have died and suffered from experimentation. She has adapted herself to survive the experimentation laid upon her. Many women have suffered experimentation of technology in childbirth, for example, the cardiotocograph, when there has been no significant evidence to support its use in many women, as described earlier. Women now may have become accepting of this technology, so that

when they enter an obstetric led environment they have adapted to seeing it as normal practice. The labour ward could be an illusion of a laboratory, where women expect to be watched and observed closely by scientists waiting to experiment on their bodies.

*"The laboratory animal is sacrificed; her suffering promises to relieve our own; she is a scapegoat and a surrogate. She is the object of transnational technoscientific surveillance and scrutiny, the centre of a multicoloured optical drama"*  
(Haraway 1997:47).

Haraway describes the person sending the messages in the language as the modest witness. They are able to acquire power to establish matters of fact, even though these may be based on no proof or evidence.

*"He is endowed with the remarkable power to establish the facts"*  
(Haraway 1997:24).

She describes the modest witness as being from the culture of no culture, which Haraway adopted from Sharon Traweek (1988). My interpretation is that the modest witness builds its own world established through its own authority, but does not have to be based on truths.

*"This is the form of modesty that pays off its practitioners in the coin of epistemological and social power"*  
(Haraway 1997:25).

The modest witness may also use what they believe to be true from the evidence they use, but it depends on where the evidence maker and the modest witness are situated. The modest witness builds its own world established through its own authority. The modest witness is a multifaceted concept. Central to the concept of situated knowledges (Haraway 1991) is the idea that there is no one truth out there to be uncovered and, as a result, all knowledge is partial and linked to the contexts in which it is created. As a concept the modest witness, in the real world situation is enacted through, for example, the value of machines. I argue that how a modest witness can influence a population is given in this following example, focusing on the use of the cardiotocograph (CTG) machine on all women in labour, even though it has never been shown to improve birth outcomes (Leveno et al 1986; Prentice and Lind 1987). This material semiotic practice has been used extensively without being based on any evidence. Its usage became challenged at the end of the 1980s and into the 1990s, when in the UK, NICE (2001) concluded that its use

on low risk women was not justified, as there was no evidence to support its usage in this group of women. Even now, with this guideline in place this piece of technology continues to be used extensively, without clinical justification. Its impact is far reaching. It still remains a regular piece of machinery on the labour ward, arguably a 'worshipable piece of artefact' in the corner of the labour room. A different type of modest witness, for example, one that practices within a natural and normal set of values professes a different view of technology. For this example I use myself. I view the CTG machine as a problem maker, rather than a problem solver. Because the woman has to remain on her back and not move, because optimum contact with the machine will be lost, this prevents mobilisation. This can then slow the labour down, the woman is then diagnosed as 'not progressing' and intervention is required. The intervention can cause fetal distress, which then leads to further intervention and a whole cascade of medicalisation occurs (Davis-Floyd 1992). My philosophy is not to take anything into the room unless it is absolutely necessary for the care of the woman. In my role as a consultant midwife I observe midwives taking machines into rooms when they are empty, even though they do not know if the next woman is going to need one. I argue that, the modest witness of these machines influence is not only medical doctors who instigated its arrival and sales to all hospitals in the land, but also some midwives, who support medicalisation of childbirth. Now, perhaps women have bought into the belief that this technology is something that is necessary for them to give birth and are also modest witnesses of the medicalised and technological? Following meetings and discussions, I align myself with my other consultant midwife colleagues to the painting of *La Mestiza Cosmica*<sup>27</sup>, described by Haraway (1997) as a modest witness of the second Christian Millennium.

*"She crushes the serpent and is in the possessions of the heavens, the place from which she protects her chosen people...she is a symbol of rebellion...she mediates between humans and the divine, the natural and the technological. She is taming a diamond-back rattlesnake with one hand and manipulating the Hubbell telescope with the other"*  
(Randolph 1993:6).

This is a romanticised view of our role, supporting the natural and normal philosophy of childbearing. Many of us are trying to do a balancing act on our technocratic biomedical labour wards by working to reduce the interventionist

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<sup>27</sup> This painting is on page 18 in Haraway (1997).

practices and increase natural physiological birth, battling against the strong culture of medicalisation that exists there. But, perhaps all of this heartache and battling is for no real gain for the women. Interestingly Lynn Randolph titles the painting 'The Illusas' meaning 'deluded woman', this perhaps sums up our role within this environment. Women may want midwives to be functioning as a technological medicalised modest witness. This is the crux of the matter, what role do women think midwives have and what role would they want them to have? This study will explore these issues.

The increase in biotechnological practices has been fuelled by capitalisation; behind these practices lay power and profit. As Haraway (1997) demonstrates these companies camouflage their wares under the guise of nature, turning natural things into a brand or a trademark; the boundaries becoming blurred and merging into one. An example of this is the hospital bed companies selling beds that move into a chair shape or can be manipulated for the woman to lean over on 'all fours'. These companies are regular attendees at midwifery conferences. These beds costs hundreds of pounds and are portrayed to hospital managers as providing the tool that will provide a normal birth. The hospitals are buying them, because it is a piece of technology, when the best answer is to use an actual chair and a mat on the floor and have no bed to increase mobility, which costs very little in comparison. These beds are being bought under the guise of increasing mobility and normal birth, when common sense tells us that you are not going to be mobile if you are on a bed.

Semiotics, as used by Haraway throughout modest witness (1997), is the study of order building or path building. It can be applied to settings, machines, bodies and programming language. Key aspects of semiotics of machines are its ability to move from signs to things and back (Achrík and Latour 1992). Material-semiotic can be defined as networks coming together to act as a whole<sup>28</sup>. It maps relations between things. Charts, pathways and guidelines used within the hospital institution are artefacts of the institution, but how they are used through social production of knowledge within this culture makes them material-semiotic as they are used to ensure conformity within the organisation.

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<sup>28</sup> Material-semiotic is used as a concept in both Actor network theory (Achrík and Latour 1992) and feminist technoscience studies (Haraway 1997).



The pressure currently placed on the majority of hospital institutions to save money has led to them ensuring that staff comply with obstetrically led clinical risk strategies to gain financial gain. NHSLA standards, previously called Clinical Negligence Scheme for Trusts (CNST) standards are adhered to within NHS hospitals in the UK and carry a financial reward if they are complied with. Guidelines for all aspects of care are part of the standards. Depending on who is involved with developing these, it can often restrict creativity and autonomy of midwives. Guidelines can often favour medicalisation, as this can be more specific to time and measurement, rather than the unpredictability of birth being spontaneous and physiological, making it easier to audit. Midwifery puts women at the centre of their care traditionally, but midwives have to comply with the guidelines and rules of the institution or face working independently of the NHS, this can therefore prevent midwives from facilitating women's experience of physiological birth. Currently the British Government are moving towards prohibiting any practitioners to practice if they do not hold indemnity insurance (DOH 2007). This cost to independent midwives is astronomic and would be totally unaffordable. This leaves midwives with no choice other than to be employed by the institution, which then restricts their ability to be able to provide woman centred care.

Haraway (1997) terms the use of Femaleman© as living after the invasion of informatics, biologics and economics. It is a product of the storm. Russ (1975) first developed the term Female Man, but Haraway takes it a stage further by putting the words together, as though there is a blurring and giving it a copyright sign, as though she/he is the property of a creator.

*"The history of copyright, with its roots in doctrines of property in the self, invites my confusion of creator and creature by its every effort to draw a clear line between subject and object, original and copy, valued and valueless"* (Haraway 1997:71).

Women and midwives have the potential of being drawn into the blurring here through the technology and medicalisation of childbirth experiences they have witnessed or lived through. This then makes them the purveyor of the technology and the culture to others. This may influence how the midwives practice and also how the women view the role of the midwife.

Imagery is a powerful tool in Haraway's thinking. I previously discussed Kelly's (1992) drawing in bodies and imagery of birth earlier on in this chapter. This picture demonstrates all of Haraway's (1997) theory in *Modest\_Witness@Second...Millenium.FemaleMan© Meets...OncoMouse™* Feminism and Technoscience. What is interesting is that the pose of the woman on the bed is reminiscent of the Sistine Chapel ceiling, where Adam puts his hand out to God in the same pose. The woman on the bed being FemaleMan© with her finger on the divine keyboard of her workstation and the fetus being Onco\_mouse™, the public fetus, stared at through the laboratory window, the machine symbolising a God like creator.

Imagery of any kind within the media provides a large forum for producing perceptions. Haraway (1997) refers to computer-generated imagery and how it can blur or totally transform images to convey messages. She uses the 1992 Cambridge Encyclopaedia of Human Evolution where there are blurred chimpanzee and human faces together on the front cover, which will be interpreted by the reader and lead to shaping social identity. She also shows the cover of Time Magazine, it was a special issue in the fall 1993 representing immigration. Its bold title is 'the new face of America' in the background of the picture is many faces of women, resulting from different "racial" crosses derived from a computer program. In the foreground is an image constructed from the computer images of the background. Therefore, all of these pictures were virtually constructed and not based on anything 'real'. This is an image of no one, not really representing anything. But it is a strong image when viewed without having all of the information surrounding this picture.

*"The programmer who gave birth to SimEve and her many siblings generated the ideal racial synthesis, whose only possible existence is in the matrices of cyberspace"*  
(Haraway 1997:259).

Women perceiving the role of a midwife or information about pregnancy, childbirth and motherhood can be wanting the impossible by viewing this type of material, something that has been computer generated and does not exist. Perceptions of how something appears to be may be a totally different experience in reality. A midwife's role may be perceived differently from the beginning of a pregnancy to how it is in the postnatal period; therefore it will be interesting to explore this aspect in an empirical study. Analysis of the data

using these theories through the principle of 'Situated Knowledges' (Haraway 1988, 1991) in the study will allow exploration of women's thoughts of their values of technology and its expectations for them, through the role of the midwife.

#### **4.6 THE INFLUENCE OF THE THEORETICAL PERSPECTIVE ON THE METHODOLOGY**

Using Haraway (1988, 1991, 1997) provides an exciting opportunity to visualise perceptions of the role of a midwife. The findings of the first phase of the study<sup>29</sup> have a strong correlation with the elements of feminist technoscience and Haraway's (1988, 1991, 1997) concepts. This has led me to conclude that this theoretical stance will allow further interpretation of perceptions through a unique lens. Within this methodology the viewpoint of truth and validity move to a different position to that adopted in the first phase of this study, which will now be discussed, along with ontology and epistemology.

##### **4.6.1 Ontology: Seeing From a Woman's Vantage Point.**

Ontology is 'how things are' within a world. It is the nature of the existence within an environment. To be able to study this from the perspective of the women it is necessary to investigate their understanding from their view of the world. Mason (1996) discusses how ontological properties can be extracted from data generated by interacting with people:

*"To talk to them, to listen to them and to gain access to their accounts and articulations"*  
(Mason 1996:40).

To discover the world through the women's eyes is my objective, to gain a detailed account of their experiences through investigating their perceptions of the midwife's role. Using the findings from the first phase of this study shows my commitment to how I wish to see from the women's vantage point. The second phase of the study will be interpreted using Haraway (1988, 1991, 1997), my chosen theoretical perspective.

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<sup>29</sup> See chapter 5.

#### **4.6.2 A New Way to See**

As already detailed, my theoretical perspective lies within Haraway's theory (1991,1997) based within feminist technoscience. She calls on social studies of technology and feminism where she has developed theory into a new realm, to help understand the new modern world we live in. Her theory relating to cyborgs (1991) and especially her interpretations in *Modest\_Witness@Second\_Millennium.FemaleMan©Meets\_OncoMouse™* (1997) provide me with the knowledge to assist my understanding of the findings for this study.

#### **4.6.3 To Sweep or Not to Sweep? Feminist Epistemology versus Postmodern Thought**

'Situated Knowledges': The Science Question in Feminism and the Privilege of 'Partial Perspective' (1988) sheds light on Haraway's vision for a feminist science. Torn between the more structured approach of feminist theory and the opportunity to 'sweep' it away by unstructured postmodern thought, I will set out my position and why I have chosen Haraway (1988, 1991,1997) to guide me. Her interests lie in the constraints generated by power and politics by those who seek knowledge (Longino and Hammonds 1990).

Three main areas that have been applied to the creation of postmodernism are from: art and architecture; French theorists and philosophers writings, who were post structuralists, for example, Foucault, Derrida, Deleuze and Guattari; and theories relating to late capitalism in society, 'post industrial', 'post fordism' and 'postmodern'. The post structuralist element has been developed further by writings from Lyotard, Baudrillard and Rorty; these have collectively joined to form the general term of 'postmodern'. Best and Kellner (1991) describe feminist 'postmodern thought' as being pulled together from the thinking of poststructuralism and postmodernism to be generally termed as 'postmodern'. This theory does not provide any set positions. Postmodern thought provides freedom to explore, as it allows for fluidity and collapsing of boundaries. It questions connections between rationality, truth/ reality and knowledge. Deconstructing binary categories in this way allows researchers to explore the power relations within the binaries, which opens up ways of thinking and places

of resistance. Postmodern thought calls for feminist epistemology to be swept away in favour of thinking as no one being female or male, but we are a being and have no gender identity. This position also offers a means of multiple 'truths', it moves away from one vantage point being superior over the other, but many points being given equal value to each other. This is in contrast to the epistemologically based philosophy of the scientific modern western world, where a high value is placed on scientific rationality.

Braidotti (1992) and Butler (1993) view deconstructing, in postmodern thought, as undermining the political feminist argument and working against the best interests of women. It challenges the authority of feminist knowledge, as no unified perception of women or feminism is possible within it. I want to retain my loyalty to feminism. To ensure this, I choose to retain some epistemological stance within my study.

Feminist standpoint is concerned with specific struggles to challenge authoritative knowledge of gender within constraints of modern thinking. Harstock, Collins and Smith are examples of feminist standpoint theorists. Harding (1987) suggests that feminist standpoint is an epistemology in the stage of transition in which participants are engaged in struggle and development. This theory positions itself away from the relativism of postmodern thought towards objectivity, but different theorists position themselves nearer than others to it, for example, Harstock (1983) positions herself closer to it than Smith (1997).

Haraway (1988,1991,1997) straddles feminist standpoint epistemology and postmodernism, using them as foundations to create new ways of positioning, by using 'partial vision and situated knowledges', which she describes as 'keeping both hands on the ends of the greasy pole'. This allowed her to retain a feminist perspective while still exploring deconstruction. Feminist standpoint epistemology acknowledges that feminist thought can only come from analysing the unique experiences of women as an oppressed social group. Haraway (1991,1997) retains this, but she also provides an option of understanding meaning through fluidity and webbed connections, which converses with our complicated modern existence. She allows exploration whilst still retaining the

connection to feminism through her epistemological position. Haraway states that feminists do want reliable knowledge:

*"This point applies whether we are talking about genes, social classes elementary particles, genders, races or texts; the point applies to the exact, natural, social and human sciences, despite the slippery ambiguities of the words ambiguity and science as we slide around the discursive terrain. In our efforts to climb the greasy pole leading to a usable doctrine of objectivity, I and most other feminists in the objectivity debates have alternately, or even simultaneously, held onto both ends of the dichotomy, which Harding describes in terms of successor science projects versus postmodernist accounts of difference and I have sketched in this chapter as radical constructivism versus feminist critical empiricism. It is of course, hard to climb when you are holding onto both ends of the pole, simultaneously or alternately"*

(Haraway 1991:188).

My choice is not to sweep away epistemology by fixing myself to purely postmodern thought. I wish to retain a link to the feminist steadiness offered from standpoint epistemology, while still being able to explore the opportunities deconstruction provides. Haraway offers this by providing a new way of seeing through 'partial vision' and 'situated knowledges'. The theory provided through Haraway allows for exploration of women and midwives perceptions of the midwife's role through a unique lens, built on a sound foundation.

#### **4.6.4 What is True and What is Valid?**

In this section I discuss epistemological foundations of relativism (interpretivism) and realism (objectivism). Knowing what is true and what is not is undeniably impossible. I have considered the competing paths to search for truth.

A relativist position provides no criteria of validity that establishes a direct relationship with actual social reality, knowledge claims and experience (Woolgar 1988). The assumption of this position is that there are multiple truths that are all valid and equal and are produced within different ways of knowing, which provides ways of rationalising the social world. This position denies that general rules can be applied across all stories, therefore allowing each story to be unique. Rather than attempting to remove them from the research process, reflexivity is an on-going process of self-awareness and is used as a tool by relativists to provide validity to their claims. This is discussed in more detail in chapter 3. A disadvantage for relativists is that their position makes them

unable to connect different accounts of reality with some actual reality, as no account is viewed as being truer than the other. This leads to further problems as relativists reject the right to judge between cultures, this becomes a direct challenge to modern feminism (Ramazanoglu and Holland 2009). I agree with Ramazanoglu and Holland (2009) when they argue that feminism is politically dismembered by relativism, which makes me nervous about moving totally away from realism, as I feel I am disregarding the roots I align myself to.

Objectivity has long been used in connection with Cartesian dualisms at the opposite end to subjectivity and implies that the researcher is able to control the research process to ensure neutral knowledge is produced. Objectivity is generally viewed as a realist approach. Subjectivity is at the opposite end of the pole within a relativist approach. In the past subjectivity has been viewed as not being able to be controlled and contaminating the truth. It has been seen as introducing bias to the scientific process, but objectivity is not as pure as it may seem.

Ramazanoglu and Holland (2009) discuss how the supposed objectivity, neutrality and rationality of scientific method allow the production of patriarchal knowledge, which work against the knowledge of gender relations. This aspect is blinkered by objectivity as it sees only one truth existing, depending on the position you view the world from. This enables loaded terms to be used and interpreted as being applied to the population as a whole. Difference is then blanketed, as only one way of viewing the world is acceptable. Harding (1993) sees some version of objectivity as essential for establishing the validity and authority of feminist knowledge through connecting this knowledge with social reality.

*“ Knowledge that is strongly objective is less partial and distorted than existing (male centred) knowledge”*  
(Harding 1993:68).

Therefore, she calls on feminists not to give up on objectivity but to use it differently, including the use of reflexivity. She suggests steps to making this a reality, these are: the researcher discusses how the knowledge production process is included in the research (reflexivity); the agendas for research questions should be grounded in the experiences of those who are ignored

through dominant beliefs and activities; to be aware strong objectivity resists relativism; strong objectivity means treating the researcher and the subjects of knowledge as visible and embodied (Harding 1993).

Haraway (1991,1997) recognises Harding's concern with objectivity, but shifts concern away from validity in scientific method to that of politics instead. She escapes the shackles of objectivity by moving to a concept of 'situated knowledges' and the privilege of 'partial perspective'. Haraway (1991) calls for researchers to resonate with women's situations, as well as our own situation. Therefore, we must recognise the complex view from her body, as well as acknowledging the complex view from our own. She recognises that no epistemological perspective is privileged.

*"I am arguing for politics and epistemologies of location, positioning and situating, where partiality and not universality is the condition of being heard to make rational knowledge claims. These are complex, contradictory, structuring and structured body, versus the view from above, from nowhere."*  
(Haraway 1991:195)

This different way of looking at validity and truth is further supplemented by her concept of diffraction. She argues that researchers should move away from reflexivity for the reason of moving beyond self-vision as the cure for self-invisibility (Haraway 1997). It can shift the focus away from the research being studied and overshadow the voices of the participants within it. She says (Haraway 1997) that if what we are searching for is a new kind of world and worldliness that we should look towards diffraction. She describes this as:

*"Diffraction patterns record the history of interaction, interference, reinforcement, difference. Diffraction is about heterogeneous history, not about originals, unlike reflections. Diffractions do not displace the same elsewhere in more or less distorted form, thereby giving rise to metaphysics"*  
(Haraway 1997:273).

I choose to hang onto some of the trustworthiness and credibility concerns of not letting go of feminism, whilst also considering the new opportunities of the future, so embrace the concepts of Haraway to use in my study.



#### **4.6.5 Situating Myself and Recognising my Diffractions**

In chapter 3<sup>30</sup> following discussing reflexivity I have provided my own values and beliefs, in an effort to lay myself 'bare'. This section in relation to Haraway's (1997) concept of diffraction is taken a step further away from reflexivity, which was used in the first phase of this study. I will attempt to unpack the issues in my history that may impact on power relations with those being researched and the implications this may have on how this study is interpreted. The distinctive feminist interrelation of politics and epistemology means that despite differences in feminist approaches to knowledge production the identification of power relations in the research process is generally seen as necessary (Ramazanoglu and Holland 2009), therefore these issues are an important part of my research journey, to lay down my situation and declare my 'situated knowledge' and the diffractions I carry as part of me.

#### **4.6.6 Recognising 'Difference'**

Within the process of my research it would be impossible for me not to recognise 'difference' within my situation as researcher. My role as consultant midwife needs me to consider the power relationship this may unintentionally create between me and the women and especially the midwives in this study.

Due to my position within the trust women and midwives may not feel that they can 'open up' to me during the interviews, as they may see me as a hierarchical figure, therefore the information they share may not be truthful. I have ensured that they are aware that the information given will be confidential and that I will use pseudonyms throughout my research to ensure their identity is not revealed. This will contribute to trust being developed between the participants and myself.

I must also be aware of my views as a mother. I have been 'blessed' by experiencing the process of birth physiologically three times.

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<sup>30</sup> See chapter 3, section 3.4.4 'Where I Come From'.

#### **4.6.7 Centring Myself**

It is important for me to recognise that my own values and beliefs could be an influence on this study, but I also believe that this study is part of me and feel that I have to put myself in the centre of it. Feminist research requires the researcher to put themselves within the centre of their research. For the first phase of my study I did try to 'bracket' myself off and keep myself detached as a researcher, recognising that it would be feasible for me to influence the focus groups with my own points of view. But, in the second phase I acknowledged I had to recognise that my background may influence the questions and the direction of the interviews, even though my main objective was to listen to the stories of women and midwives. Hunt (2004) discusses how it is naïve to believe that there will always be non-hierarchical relations between the researcher and the researched. She refers to the work of Ong (1995) who argues that the image of the powerless respondent has altered with the recognition that the power of the researcher is often only partial, illusory, tenuous and can be confused with the researcher's responsibility. It must also be recognised with the fact that researchers may be more powerfully positioned when out of the interviews or observations, as they are writing the accounts. It was important for me to recognise that the women may see me as an authoritative figure who was trying to test their intelligence, themselves believing that their were right and wrong answers to my questions. Therefore, I felt it was important to discuss with them that all of us have different perceptions of something and there are no right and wrong answers to my questions and assured them that their identities would not be disclosed. I assured them that I was there as a researcher, not as a midwife and that I needed to learn about their experiences to help understand the world from their viewpoint. Even though I said that I was not there as a midwife I knew in my heart that I was! I had to recognise that the experiences and views I have within what I am, may overspill into my research and this I have to acknowledge and be aware of.

Feminist research acknowledges that the researcher is part of the research and is not separated from it. I collected all of the data, therefore other researcher's 'situated knowledges' or diffractions (Haraway 1988, 1991, 1997) could not have any influence on the data.

## **4.7 ETHICAL PRINCIPLES**

The issues surrounding trustworthiness are complicated in feminist research, as I have already explored. Using situated knowledges and diffraction (Haraway 1991,1997) sets out my commitment to ensuring my research study is performed ethically in a unique and original concept. My experience of the research ethics committee for the second phase of this study was much improved from the experience of the first phase<sup>31</sup>.

### **4.7.1 Harm**

The harm likely to be experienced is the same as in the first phase<sup>32</sup>, except for the added complexity of longitudinal interviews. Discussing experiences in an interview situation may be difficult for some women, but because there are 4 interviews for each woman the design has the potential to cause more psychological harm as distressing experiences may repeatedly be revisited. This may also provide satisfaction for some of the women, as this may enable reflection, solace and closure on the experience. The addition of the midwives being interviewed also adds in a new group who have the potential of being harmed psychologically if distressing experiences are recalled. Both groups were aware that they could withdraw from the study at anytime without this affecting their care or employment.

### **4.7.2 Consent**

Verbal and written consent was gained from the women and midwife participants in the second phase following reading the information sheets provided. Information sheets were given twenty- four hours before consent was gained, so participants had time to consider the project and the implications of participating.

### **4.7.3 Confidentiality**

Participants were aware that pseudonyms would be used, to ensure anonymity, which they were able to choose. Data would be kept within a locked cabinet on NHS premises. All data would be stored and collected by myself only.

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<sup>31</sup> See section 3.3.4 in chapter 3.

<sup>32</sup> See section 3.3.1 in chapter 3.

#### **4.7.4 My Ethics Committee Experience**

Ethical approval for the second phase of this study was approved. I applied online for the second phase research study. This process seemed much simpler than the previous experience and once you had applied they gave dates of the earliest committee available. It was a much smoother and speedier process. I attended the committee in 2008 on my own, as due to the efficiency of the system I was given an early date, but unfortunately my supervisors were unavailable to attend.

The committee consisted of six members, all whom introduced themselves. I was asked about three questions, which were all straightforward, which were asked by a qualitative researcher. I felt that they all understood the relevance of my study and were very supportive. I was asked to make a few changes to my information sheet and consent form and given approval to go ahead as long as I agreed to make the changes.

### **4.8 RESEARCH DESIGN**

The second phase of the study is led by my chosen theoretical perspective, Haraway (1988, 1991, 1997). This perspective has associated implications to the methodology of this study, which I have visited in section 4.6. The design for the second phase incorporates different methods to enhance the mix of methods contributing to the credibility of this study.

The findings from the first phase informed the second phase of the study. In the second phase I decided to concentrate on the women receiving consultant-led care only, therefore exploring the views of a midwife's role within a consultant unit. This exploration is unique, as a study has not been performed previously on the views of consultant led women in relation to the role of the midwife.

#### **4.8.1 Sample**

Purposive samples were also used in this phase. Following the findings from the first phase and based on the lack of current literature available in relation to consultant led care in contemporary midwifery practice, my supervisory team and I agreed that investigating the view of women receiving consultant led care would provide a unique perspective of their views in relation to the role of the

midwife. Women experiencing consultant led care would be at an increased likelihood of experiencing technology and interventions, as they would have been assessed with some complication or an anticipated complication in the antenatal, intrapartum or postnatal period. Therefore this sample will be appropriate for using Haraway's (1991, 1997) notions, especially of the cyborg to investigate the views of women experiencing this model of care in relation to technology and the role of the midwife.

The sample of women in this second phase of the study, were recruited from a different area in the West Midlands region. They were recruited from a Hospital Trust, which provides two birth environments. These are the woman's home and the consultant led labour ward. The Trust has two hospitals providing the same environments. Women and midwives from both hospitals were included in the study. The sample of women, were all receiving consultant led care and all intended to deliver their baby in the consultant led labour ward setting. The sample of midwives for the second phase were all working within the consultant led setting at the time of the woman's birth experience.

#### **4.8.2 Recruitment**

The purposive samples in the second phase were primigravida women receiving consultant led care. They had been identified in antenatal clinic at their initial consultant appointment and approached by myself to request recruitment. A written information sheet was provided and the study explained verbally by myself. When they left the clinic I asked if they would be interested in taking part, if they agreed they gave me their contact details. I agreed to contact them after twenty-four hours to ensure they still wanted to take part. If they did, I arranged to see them at their home to gain verbal and written consent for the study. I also provided another information sheet and ensured they understood it, prior to completion of written consent. Ten women were recruited and were part of this phase. I used a small number to ensure I was able to investigate their perceptions over their pregnancy, birth and postpartum experiences. This enabled me to observe for any changes in perceptions across this continuum and explore these perceptions in a much deeper sense. At each interview I was consciously using Haraway's notions to investigate their perceptions, through questioning with these in mind. The midwives who were in

attendance at the birth were approached regarding the study and asked if they would participate. I approached them all in person, explaining the study, its implications for them and provided them with an information sheet. I contacted them again twenty-four hours following this initial contact. All of the ten midwives agreed to participate.

#### **4.8.3 Methods**

A mixture of data collection methods were utilised.

A diary was given to the women at mid-trimester of their pregnancy to record their thoughts about the midwife's role throughout their journey up to 6 weeks in the post-natal period, so they could record an entry each time they were seen by the community midwife or at the hospital. Diaries can provide researchers with an in-depth personal perspective from a particular time point and also have the capacity to show how feelings or events may alter over a time period (Walsh and Baker 2004). This qualitative research method offers the opportunity of capturing perspectives of the midwife's role from a different angle, which also supplements other methods to provide a mixture of research methods. Using this approach offers the opportunity to explore perceptions using Haraway's notions across different approaches of data collection, to provide further validity of the findings.

Each woman received an in-depth interview during the mid-trimester (20-24 weeks gestation) when a diary was distributed to her. She then had a further three interviews at 36-38 weeks of pregnancy, following the birth and at six weeks in the postnatal period. The midwives who were with the woman at the birth of their babies were also interviewed to establish how they felt they were perceived. The interviews of both the women and the midwives were semi-structured to enable exploration of the themes discovered in the first phase. Semi-structured interviews allow for a dynamic operation between researcher and the participant, as they both shape the focus of the enquiry (Walsh and Baker 2004). Interviews will vary on an individual basis with each participant as responses to initial questions are explored, with the direction and flow being led by both the researcher and the participant.

The research method in phase one combines with the two from this second phase, to provide a multiple exploration from three different angles to investigate perceptions of the midwife's role. This investigation goes a step further by allowing for reflection of the women's perceptions with those of the midwife's, which provides a unique aspect to this study, to portfolio a comprehensive collection of data.

#### **4.8.4 Aims and Objectives**

The overall aim for both phases of this study is to explore the views of midwives and women, relating to the role of the midwife. The themes identified in the first phase have been used as a basis to explore further the midwife's role in a consultant led setting. This is achieved using a postmodern epistemological approach, concerning feminist technoscience, focusing on the work of Haraway (1991,1997).

The objectives are to:

- Explore how women receiving consultant led care view the role of the midwife through their pregnancy, birth and the post-natal period.
- Explore the themes identified in the first phase further in the second phase.
- Compare and contrast the women's and midwife's perceptions in the second phase.

#### **4.8.5 Moderation**

The semi-structured interview plan was formed with the assistance of my supervisory team. I consulted with them throughout the four stages of the women's interviews and following the midwives interviews. We discussed the data and I consulted with them throughout the analysis stage.

#### **4.8.6 Member Checking**

I posted the transcripts of the midwife's and the women's interviews to them (the four together) and provided my contact details for them to contact me if they felt it was not a true reflection of their interviews. I decided to do this, not that it was led by Haraway's (1991. 1997) writings, but because I felt that I was

being open and honest with the participants and this provided credibility to my study.<sup>33</sup>

#### **4.9 DATA MANAGEMENT AND ANALYSIS**

As discussed previously, my methodology is guided by Haraway's (1988, 1991, 1997) theories. The application of this theoretical lens on the emergent themes identified through data analysis adds a unique way of 'seeing'. Haraway (1988, 1991, 1997) has not conducted any empirical research studies as a kind typically undertaken in midwifery, her notions and writings are based on observations of the world and secondary sources. To the best of my knowledge, the only other empirical study, which draws on Haraway's work, is Kingdon (2007). There is therefore, no set format of how to conduct data management or analysis using the work of Haraway. In fact the whole subject of data analysis in qualitative work is largely not discussed (Silverman 1993, Bryman and Burgess 1994). There appears to be a drive towards using computer software packages for analysing data by qualitative researchers, therefore avoiding the discussions around data analysis (Mauthner and Doucet 1998). Grounded theory (Corbin and Strauss 1990) however, does provide guidance of analysis, with the incorporation of constant comparative method, but falls within a theoretical concept. I want to use a tool for analysis, but not lose the theoretical commitment to Haraway's (1988, 1991, 1997) work. It is important to my principles that the participant voices are heard above the 'noise' and not lost within the analysis process. Kingdon's (1997) work differed to this study, as the methods consisted of questionnaire and women's interviews. This study uses diaries and midwives' voices, as well as those of women, making the data more 'messy' and needing some sort of organisation. Parr (1998) discusses how she struggled to persist in staying true to one theoretical approach and proceeded to have a foot in each camp, moving away from having to engage with only one pre-existing body of theory. Mauthner and Doucett (1998) recognise that individual researchers use and adapt particular methods in their own individual ways. This is the position that I have moved towards when considering analysis of the data.

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<sup>33</sup> See 3.4.9 for further justification on my reasoning to use member checking.



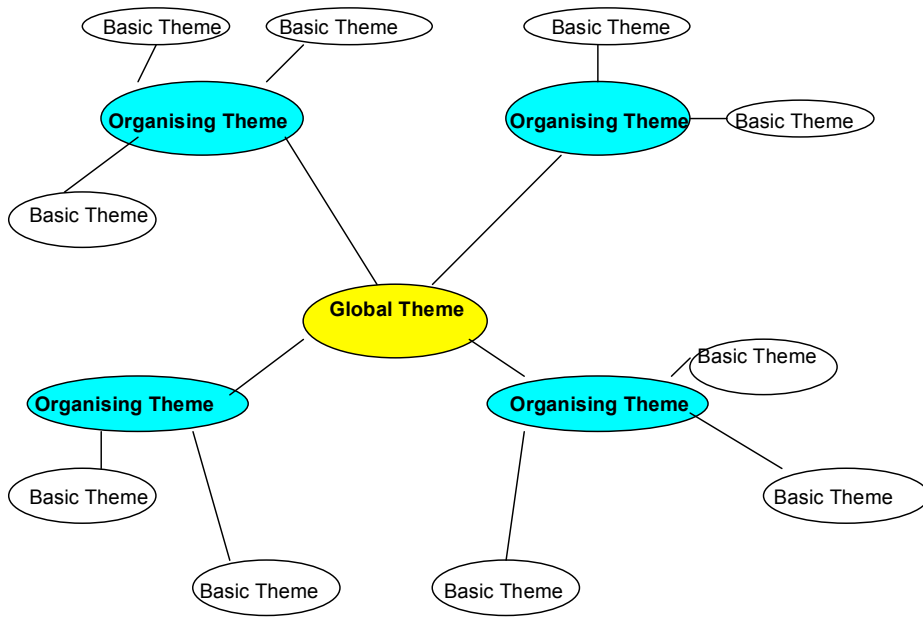
For this second phase I chose to perform thematic analysis to identify themes emerging from the data, which I performed by hand. I was drawn towards using a computerised programme to do this, but concluded that I would be more familiar with the themes and data if I used a manual method, allowing myself to feel fully immersed. This was to allow themes to come directly from the women and midwives to obtain an accurate view of their perceptions. To assist me with the two different groups of participants and the two different research methods I decided to use thematic network analysis (Attride-Stirling 2001) to assist organisation of the themes. Attride-Stirling (1998) struggled to find a way of organising her data while performing feminist research on the naturalisation of marriage. She therefore, developed thematic network analysis while using feminist theory. She used the idea of networks from Toulmin's (1958) argumentation theory, which aimed to provide a structured method for analysing negotiation processes. Thematic analysis unearths the themes at different levels within the data and thematic networks aim to facilitate the depiction and structuring of thesis themes. I applied the principles of Haraway's situated knowledges and diffraction (1988, 1991, 1997), while identifying the emerging themes and to help in the process of building networks. The appreciation of where women are situated at this particular point in time and the diffractions of myself as a researcher were considered when analysing the data and through interpretation of the networks produced<sup>34</sup>.

Thematic networks provide a system to extract data from the lowest order evident in the text, which are labelled as 'basic themes'. These basic themes then feed into the more abstract principles, labelled as 'organising themes'. The organising themes are capsulated around the global theme. The global theme is an overall theme, which has been built up from the basic and then the organising themes, which feed into it. See figure 4.1. The themes are explained in more detail below.

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<sup>34</sup> Situated knowledges and diffraction are discussed in more detail in section 4.6.

**Figure 4.1 Thematic networks analysis (Attride-Stirling 2001)**



The themes:

Basic theme- simple characteristic of the data. On its own it is of little significance, but when taken into context with other basic themes, they all represent together an organising theme.

Organising theme- organises clusters of basic themes to provide greater significance and reveals more of what is happening within the data.

Global theme- this unites the organising themes, which encompasses the principal metaphors in the data as a whole. It is a summary of the main themes, but it is also a revealing interpretation of the data collected.

I chose to use Attride-Stirling's (2001) thematic network analysis as it provides fluidity between the themes, while showing interconnectivity throughout the network. In this study the themes, which emerge, are interpreted using Haraway's (1988, 1991, 1997) theory based on feminist technoscience. Following identification they are placed within a thematic network. This provides understanding of the role of the midwife viewed through the eyes of women and reflected against midwives' perceptions.

#### **4.9.1 Data Analysis**

I transcribed verbatim the tape-recorded interviews and incorporated any field notes into each transcription. I analysed the data from each of the women's interviews at every interview time point for example, ten interviews were transcribed following their first interview at 20-24 weeks gestation. All of the women and midwives were given their own colour code. Sticky colour tapes were used to identify the women's interview time points the information related to.<sup>35</sup> Midwives were matched to the women they were caring for at the birth of their baby their colour code allowing me to reference back to find out the corresponding woman.

I conducted a data reduction phase through line-by-line reading of the text and coding words and basic themes, which I transferred to another sheet, using the codes discussed previously<sup>36</sup>. As the number of interviews increased, more basic themes were added, collapsed and merged. The basic themes were constantly being reviewed. Each basic theme was labelled succinctly.

I followed Attride-Stirling's (2001) process, as discussed in section 4.9; I grouped basic themes together by finding common characteristics. I then amalgamated them into an organising theme that reflected the grouping of the basic themes<sup>37</sup>. I then spent some time to reflect on the organising themes and the basic themes. This reflection allowed me time to identify the global theme, relating to each network. Separate networks were produced for the women and the midwives.

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<sup>35</sup> An example of this is included in appendix 5.

<sup>36</sup> This is included in appendix 5, relating to the women's themes.

<sup>37</sup> This is shown in appendix 5, relating to the women's themes.

I then reflected longitudinally down through the women's interviews to identify particular characteristics of the individual women and how they were situated at this point in time. I found this to be a very useful exercise, as it allowed me to see if the women's viewpoints had changed through their childbearing experience. I could also then compare these data with the midwife that was present at the birth of their baby. This comparison is detailed in Appendix 3.

My choice was not to use computer- assisted data analysis software, but to do the analysis by hand. I became increasingly familiar with the data, as I had also performed the transcribing of the data. I felt that I knew it 'inside and out' and could feel the experiences of both the women and the midwives. This method also gave me time and space to reflect deeply on the data. I engaged in a constant refinement and verification process of the networks I had produced to ensure no further basic themes or organisational themes emerged. I felt that I had reached 'saturation' of the data.

As Attride-Stirling (2001) asserts, the thematic networks constitute a tool in the analysis, not the analysis itself. Haraway's (1991, 1997) principles were not suffocated by this organisation. In fact, the networks allowed the data themes to remain visual, authorising a way of working them up into pertinent groupings and relevance. The networks enabled me to return to the transcripts and re-read them in relation to the networks in a cyclical way. I was then able to describe each network in turn and illustrate the description with sections of text. This framework supported me in relating the data to a feminist technoscience perspective, by exploring the networks and summarising the themes and the patterns characterising them. In order to make increasing sense of the data I utilised the developing networks along with ongoing reading of relevant literature to provide me with a deeper conceptual awareness that, in turn, supported me in a rich and in-depth analysis. This is discussed in chapter 7.

#### 4.10 CONCLUSION

In this chapter I have presented the rationale for my chosen theoretical perspective of Haraway, particularly in relation to the cyborg (1991) and her work in *Modest\_Witness@Second\_Millennium.FemaleMan@Meets\_OncoMouse™* (1997).

Feminist theory in relation to the role of the midwife has pulled together the roots of this project; This Chapter justifies my reasoning for using a postmodern feminist technoscience perspective to view this study. I have outlined why I believe the adoption of Haraway's concepts of the cyborg, modest witness, semiotic materials, the acknowledgement of OncoMouse™ and FemaleMan@ are relevant to my study and will help to facilitate understanding of women's perceptions of a midwife's role through their experiential knowledge. Within this chapter I have woven through my justification for using Haraway's 'Situated Knowledges and Partial Perspective' (1991) as a way of 'seeing' how women and midwives 'come to know'. I have explored the relevance of moving towards diffractions from reflexivity, in relation to Haraway's (1991, 1997) theory and issues around clarifying truth and validity.

The methodology relating to the second phase of this study has been discussed within this chapter. I have clarified my research design and provided justification for the methods chosen. I have communicated the relevance of using a structured thematic analytic approach to the principles of Haraway's (1988, 1991, 1987) writings. I have justified my reasons for developing and diversifying within the feminist field, to ensure themes do not get lost within the different data collected. As Mauthner and Doucet (1998) state:

*“ Are research texts on data analysis intended to be followed step by step? How many researchers who describe using particular methods actually follow all the steps as specified within the original text?.....to what extent do methods evolve as different researchers use and adapt them?”*  
(Mauthner and Doucet 1998:123).

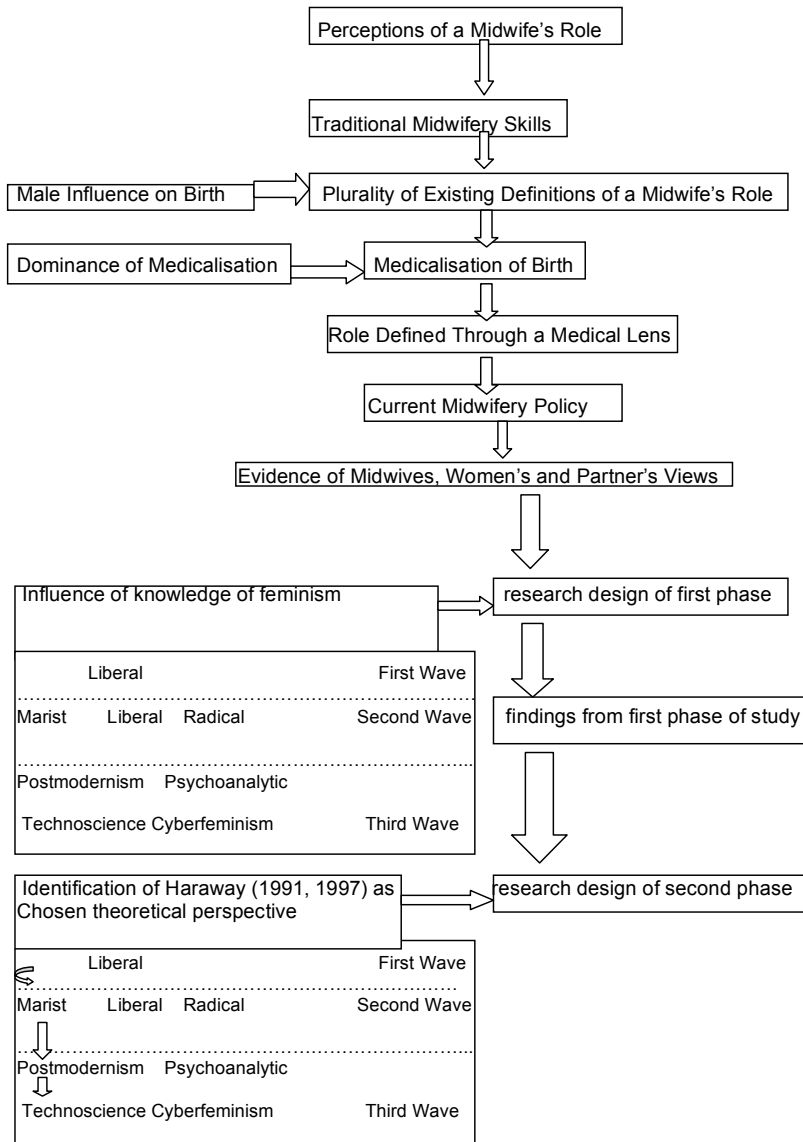
The use of a structured analysis has enhanced rather than disrupted the research process and has provided a positive contribution to the study.

My experience of the research ethics committee in the second phase reassured me that not all ethics committees are the same and that there are some

understanding, helpful and supportive committees out there for researchers to access.

This longitudinal empirical study is guided by a postmodern feminist technoscience perspective, which provides understanding of how women and midwives view the role of the midwife. This along with the different sources of methods used makes this study unique. My only quest is for voices of women and midwives to be heard, through acknowledging their accounts in an honest and open methodological content. Figure 4.2 tracks my research journey so far.

**Figure 4.2 Research Journey**



## **CHAPTER 5**

### **AN INITIAL EXPLORATION OF WOMEN'S THOUGHTS ON WHAT A MIDWIFE DOES**

#### **5.1 INTRODUCTION**

Within the previous chapters I have argued that we do not currently have enough evidence on women's perceptions of a midwife's role and how they 'come to know' (Kingdon 2007). Chapter 3 outlined the search for a theoretical perspective and the methodology relating to the first phase of the study. The methodology of the second phase has been outlined in chapter 4. This chapter also provided justification for adopting a postmodern feminist technoscience theoretical stance.

The findings of this study are presented in two chapters, 5 and 6. Chapter 5 discusses the initial exploratory phase, which sets the direction for a deeper insight into perceptions of the midwife's role in the findings of the second phase in chapter 6. Although I did not come to my theoretical stance until after I had completed the first phase, therefore Haraway's stance did not provide any influence while conducting the first phase of this study. But, I have chosen to discuss the findings from the first phase relating to Haraway's (1988, 1991, 1997) concept of 'situated knowledges' within this thesis. The reasoning for this is to look deeper into the responses to not just see 'authoritative knowledge', but to value the usefulness of embodied, fluid and located knowledge instead.

This chapter explores women's thoughts to find out how they perceive the role of a midwife. This provides direction for the second phase and informs a semi-structured interview schedule for it. The findings from this initial phase are presented here and discussed with the findings from the second phase with their implications in chapter 7. The focus groups generated important themes, which provide insight into women's thoughts about the role of the midwife.



## 5.2 INVESTIGATING WOMEN'S PERCEPTIONS

The exploratory phase provided a broad spectrum of women's views to inform the investigation of women's perceptions of a midwife's role. The method of data collection for this phase consisted of four focus groups<sup>38</sup>:

1. Women experiencing midwifery led care in the postnatal period.
2. Women experiencing consultant led care in the postnatal period.
3. Women who are multigravida in the antenatal period of pregnancy.
4. Women who are primigravida in the antenatal period.

This chapter will provide a clear understanding of the findings from the initial phase of the study, which provided the direction for the second phase of the research. Each focus group has undergone thematic analysis<sup>39</sup>

Whilst analysing the data it became apparent that women's views reflected two clear viewpoints: women experiencing midwifery led care; and women experiencing consultant led care. I was surprised at how differentiated the two different viewpoints were, therefore I checked and rechecked over the data, to ensure I had analysed the findings correctly. I also conferred with my supervisory team, to minimise the chances of interpreter bias. This dichotomy may have resulted from not using a theoretical direction to guide this phase.

Following identification of the findings in the first phase I was led to my chosen theoretical stance. I later revisited the findings and considered the situated approaches of how women come to know using Haraway (1991, 1997). I have therefore interpreted the findings of this phase in relation to Haraway's (1991, 1997) concepts below in section 5.3 and 5.4.

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<sup>38</sup> Further information about these focus groups can be found in chapter 3.

<sup>39</sup> See chapter 3 for details of methodology relating to the first phase of the study.

### **5.3 WOMEN'S VIEWS OF THE ROLE OF THE MIDWIFE**

The themes identified were: midwife's influence on women's empowerment; influence of family, friends and media; technology and monitoring; and the influence of doctors. The overarching theme was that women experiencing midwifery led care have a different view of the midwife's role compared to women experiencing consultant led care. The findings within each theme are now discussed.

#### **5.3.1 The Influence of Midwives on Women's Empowerment**

My personal conceptualisation of empowerment is of midwives giving support, reassurance and encouragement which produces self-belief in the women that they 'can get through' labour and 'do it' themselves. This appears to be achieved by women being given information about pregnancy and labour being a normal physiological process by midwives. This results in the women feeling strengthened and believing that what they are experiencing is a normal physiological process and they are encouraged to embrace it rather than be fearful of it. This is how the midwifery led women 'came to know' about birth, how they situated themselves to deal with the process. I am presuming that the midwives have a strong belief themselves in the physiological birth process for them to feel confident to convey this empowerment that the women felt. The midwives effectively work as 'modest witnesses' of the normality of birth probably derived from their previous experiences of observing birth. This presumption may be inaccurate, as I did not interview the midwives who cared for these women, so I am unable to be certain; I can only conclude this from the women's responses.

It appeared that the midwives had a positive influence on the empowerment women felt who had experienced Midwifery-Led Care throughout the continuum of this childbirth experience. Women expressed how they shared a friendship connection and how the midwife encouraged them to have faith in their body and soul enabling them to deal with this childbirth experience. This was evident from their body language (e.g. emotional facial expressions) and their narratives.

In the focus group when I asked the women what they thought the role of the midwife was I received the following responses:

*"It was all my choices; she let me take the lead, if I wanted to be in a certain position that's what I did. Last time (previous birth on labour ward) I ended up on my back, I didn't really sort of move, I didn't! I'd got all these ideas beforehand, I wanted to be in this position and that position, but I didn't. This time I was standing up, kneeling down.... She made me believe in myself, that I could do it"*

Sarah (MLC, P/N, Homebirth: Transcript 1A,p2).

*"She let me basically get on with it. My previous experience (on labour ward) they were sort of like they were in charge, you just go with what they want to do. My midwife this time kept saying where do you want it, you can have it anywhere upstairs, downstairs, wherever. She let me be in control. I knew what I had to do and she helped me do it"*

Liz (MLC, P/N, Homebirth: 1A,p2).

*"To make me be able to do it, to give birth. It's like you feel in control...she really helped me through"*

Louise (MLC, P/N, Waterbirth on MLU: Transcript 1A,p2).

This empowerment extended into a special bond and emotional attachment.

*"She did so much more than I thought, I did feel really close to mine, I got really emotional the last time I saw her"*

Sarah (MLC, P/N, Homebirth: Transcript 1A,p2).

*"She was amazing, yes, I couldn't have done it without her, she helped me so much. It was just the way that she was, she made me know that I could do it"*

Louise (MLC, P/N, Waterbirth on MLU: Transcript 1A,p2).

This embodied belief in themselves seemed to be fed from the midwives and this empowerment the women felt seemed to support physiological birth happening. They wanted to make their own decisions, managed without pharmacological pain relief, liked having a known midwife and they all birthed naturally. They viewed birth as a social, rather than medical event.

There is no evidence within this study of women who had experienced consultant led care being influenced by the midwife in this way; their 'situated knowledge' was different.

### 5.3.2 The Influence of the Media, Family and Friends on Women's Views of the Role of the Midwife

The media can be extremely powerful in relation to birth (Betterton 1996). This has been discussed in greater depth in Chapter 3<sup>40</sup>. There are many television programmes that can influence how women interpret the role of the midwife, which contain real life or fictional interpretations of pregnancy, labour and birth. Family and friends can be equally as valuable for information about the birth process and can influence women's perceptions of the midwife's role. When women are finding out about pregnancy and birth it influences how they think the midwife functions with the role.

The primigravida (primip) antenatal group were influenced by family and through the media.

*"Desperate Midwives was on and some women got on well with their midwives and some did not..... I didn't get on with my community midwife, so at least it opened my mind up to realise that I might not get on with her"*

Tara (Primip, CLC, A/N: Transcript 3A,p1).

*"I saw a lot of normal births on television; I was expecting to have a normal birth, but the doctor said I would have to see what happens as lots of things can go wrong"*

Susan (Primip, A/N, CLC: Transcript 3A,p1).

This shows how the influence of media can shape a woman's expectations of her forthcoming birth experience. It is positive and encouraging that Susan had seen a lot of normal births on television, but disappointing that the doctor was not supportive and imparting his influence as a modest witness of birth being complicated and needing to be controlled.

Family and friends also influenced their perceptions about the midwife's role, pregnancy and birth:

*"My friends and my family have influenced me the most on what to expect"*

Debbie (P/N, CLC, Primip: Transcript 4A,p1).

*"My mum and my sister told me what it was going to be like....you can't read it can you? It's just about how it is, I have taken my sisters advice, I'm going to have an epidural"*

Tara (Primip, A/N, CLC: Transcript 7A).

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<sup>40</sup> See section 3.4 in chapter 3.

Friend's experiences are likely to be more recent and relate to birth choices offered at the current time, which will be the same as the choices offered to the women. Family's views of birth and the role of the midwife may be influenced by previous experiences and historically how the business of birth was performed at that time. Midwifery practice at the grandmother's time of giving birth to her daughter is most likely to be different to practice happening today, as it has changed over time. Mothers have anxieties about their daughters becoming a mother themselves and want to advise and protect her within this new experience. Her partner's mother may also feel the same (Marchant 2004). Therefore first time mothers have a lot of support and advice, but it may conflict to that given by the midwife.

The multigravida (multip), antenatal (A/N) women, also experiencing consultant led care (CLC), were influenced by their previous experiences.

They talked about their previous experiences of childbirth and how they expected it to be the same this time:

*"We have done it all before (childbirth) so it is second nature"*  
Shona, (A/N, CLC, Multip: Transcript 2A,p1).

*"Yes, I agree, I know now what they want me to do because of having the other one, I just do what I'm told"*  
Carol (A/N, CLC, Multip: Transcript 2A,p1).

By Shona describing her experiences as second nature suggests that she does not view them as natural. The consultant led care women seemed to have an underlying acceptance of what they were offered.

*"I just do what I am told.... It's not worth planning what I want to do, he (Mr D..Consultant) will tell me what he wants and I will do it, because he knows what's best"*  
Shona (A/N, CLC, Multip: Transcript 2A,p1).

Shauna trusts the doctor to make decisions for her; she does not appear to be object that the doctor is asserting power and control over her decisions. She accepts that the doctor has the authoritative knowledge.

The women who were experiencing birth for the first time did seek out some information of what they wanted, but there was an accepting compliance with the package of care they were offered, which correlates with other evidence (Stapleton et al 2002).

*"I saw a lot of normal births on television; I am expecting to have a normal birth, but the doctor said we would have to see what happens as lots of things can go wrong"*

Susan (Primip, P/N, CLC. Transcript 3A,p1).

Susan did research her choice, but unfortunately was not supported or encouraged by the doctor to aim for a normal birth, but informed that something would be likely to go wrong in her pregnancy or during labour, causing unnecessary anxiety.

Louise (MLC, P/N) had used magazines and Sarah (MLC, P/N) used television to research their choices. Liz in the same group used books, midwives and friends to research her birth choices.

*"In a magazine it said that if you have a homebirth you are less likely to have pain relief and will be more relaxed...my partner thought I was mad, but it was my choice, my decision"*

Louise (MLC, P/N: Transcript 1A,p1).

*"I watched a lot of Discovery Health to make sure I knew as much about homebirth as I could possibly learn"*

Sarah (MLC, P/N: Transcript 1A,p1).

*"My midwife has told me so much, but I also found out about pregnancy and birth from my friends who lent me some fabulous books that I found useful"*

(Liz, MLC, P/N: Transcript 1A,p1).

Women experiencing midwifery led care appeared to research the information they needed to make an informed choice from various sources.

### **5.3.3 Technology and Monitoring: how women 'come to know' what the midwife does**

The women receiving midwifery led care felt the main role of the midwife was about creating an empowerment belief in women to 'get through' the normal physiological birth process. Technology and monitoring were both a significant feature within the data from the responses from women receiving consultant led care, when they were asked to identify what the role of the midwife was. Monitoring the pregnancy, labour and birth were perceived as the midwife's main role, when I asked what they thought the midwife's function was:

*"She obviously does the routine blood tests, checks my water, the heartbeat and where the baby is.... She does very close monitoring, I'm very impressed"*

Tara (A/N, Primip, CLC: Transcript 2Ap2).

"She monitors the progress and if there are any complications she refers you to the right area...she is there to support me by monitoring, like checking my blood pressure and sending me for scans"

Jane (P/N, CLC: Transcript 4Ap2).

*"They monitor, they tell me what's in my water, what my blood is like and what my blood pressure is and refer to the doctor"*

Carol (A/N, Multip, CLC: Transcript 2Ap2).

The women seem to view the role of the midwife as performing tasks and using technology to do this. Women appear to get to know about their pregnancy through technological interventions. The women do not seem to view themselves holistically as a whole person, but are disembodied, viewing themselves as different parts needing regulation. They view the midwife as knowing her pregnancy through tasks relating to technology and measurement of their body parts. The women then perceive themselves as not knowing their pregnancy and baby unless they are given confirmation that everything is fine from the results the technology has produced through communication with the midwife. The women appear to rely on the midwife to tell them if they and their baby are fine, rather than listening to their body from their own feelings and the communication they receive from their baby. They are not 'tuned in' to listening from within. They are using the material-semiotic network to listen to their baby rather than hearing it 'first hand', themselves.

The previous sections have shown that health professionals can influence how women 'see' birth through communication. Women receiving consultant led care defined the midwife as being useful in translating what had been said to them by the doctor and felt that providing a translation of syntactics was a main part of the midwife's role:

*"The midwife seems to put it into better words, so it's not so scary"*

Debbie (P/N, Primip, CLC: Transcript 4A,p2).

*"When I went to see the doctor I didn't really understand what he was on about, so I waited until I saw the midwife and she explained to me what he had written in my notes, the words they use I just don't understand it. The midwife made it really easy for me to understand"*

Susan (A/N, Primip, CLC: Transcript 3A,p2).

The women did not question the doctor or ask for a different explanation, they accepted that they needed a translator to integrate the syntactics to their own

understanding and accepted that the doctor had the authoritative knowledge, as they did not question the information given.

Women experiencing consultant led care valued technology, Carol suggesting that technology is progressive:

*"She uses all the technology that is now available, in the bad old days they did not have scans or monitors"*

Carol (Multip, A/N, CLC: Transcript 2A,p3).

*"She listened to the heartbeat with a machine thing and the scans reassured me that baby was fine"*

Jane (P/N, CLC: Transcript 4A,p3).

Women seemed to enjoy connecting to their baby in this way, as they felt reassured by this experience and trusted in the machines to be truthful. Semiotic material connections were made between the women and the machines.

In contrast to this Sarah in the midwifery led care postnatal group positions herself differently. She suggests that monitoring and technology are a disadvantage to a woman in labour, she describes the care of her friend in labour who was having her baby on the consultant led care labour ward in the hospital:

*"I decided to have a homebirth after seeing my friend in hospital. She had her baby on the main labour ward. The experience made me want a homebirth more.... My friend she was monitored, she went through gas and air, pethidine and could not move off the bed and then had an epidural put in. The midwife told her she was going to perform an internal, when I looked she had catheterised her without telling her, I felt that was wrong. All of these things just led to more and more complicated things, I just thought I don't want all that monitoring and drips and everything I just want to be me and feel in control, as long as I don't have all this, I thought yes, I will be fine at home"*

Sarah (P/N, MLC: Transcript 1Ap3).

Sarah seems to 'come to know' birth by being free from intervention. She seems to relate this as to being able to stay as 'herself'. This indicates that she did not see her friend as being 'herself', within this environment with these interventions happening. This discloses that she views her friend as being disembodied and she wanted to stay embodied for her birth experience. She views her decision for choosing a homebirth as being able to stay embodied.



### 5.3.4 How Women Perceive the Role of the Doctor, in Contrast to the Role of the Midwife

With the exception of the midwifery led care postnatal group, when asked about what women think a doctor does, all of the women felt that the doctor was the decision maker and the midwives carried out his instructions:

*"I think the midwives need the doctor to make the decisions. The midwife is constantly waiting for the doctor to decide on the results she has"*  
Susan (CLC, A/N, Primip: Transcript 3A,p4).

*"The midwives do the monitoring on a regular basis, but it is definitely the consultant that is the one who makes the decisions"*  
Shona (CLC, A/N, Multip: Transcript 2A,p4).

The assumption that I made earlier in section 5.3.3 in relation to women waiting for the midwife to tell her if everything was fine from the results via the technology is dispelled here. The women see the midwife giving the results to the doctor; therefore she perceives it as the doctor's role to inform her if the pregnancy, labour or birth is progressing normally, not the midwife. The women view the doctor as the powerful decision maker and the midwife as his handmaiden. The way in which midwives conduct their role leads to women interpreting what they see. The women view the doctor as having the authoritative knowledge, which she has 'come to know' (Kingdon 1997) by viewing interactions between midwives and doctors. She interprets the work of this type of 'modest witness', one that appears to be supporting the technocratic birth culture, rather than the normality of birth. How midwives have come to practice within technocratic environments in this way has been discussed in Chapter 2<sup>41</sup> and Chapter 3<sup>42</sup>. Witz (1992) explains how the power of the medical profession to set limits on midwifery practice was related to its position as a male dominated institution and its relationship to the state. By setting limits within the NHS hierarchical structure this inhibits the midwife making the decisions, due to guidelines and rules set down by the medical profession within the institution. One of the most interesting aspects of the data collected was from the women receiving consultant led care regarding their choice of health professional:

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<sup>41</sup> See chapter 2, section 2.2.5.6 The Emergence of Technocratic Birth

<sup>42</sup> See chapter 4, section 4.2 Feminist Theory and the Role of the Midwife

*" Well I had to have a consultant because of my problems. I am under Mr D, he's had all of mine"*

Shona (CLC, A/N, Multip: Transcript 2A,p4).

This comment is extremely interesting as the doctor could be mistaken for the woman's partner. I am undecided if this is related to the culture within the institutional environment or perhaps related to trust in the doctor by her. She appears to situate herself as owned by Mr D. This also correlates with Carol's response:

*"I am a diabetic, so I am always under Mr B, they always look at me as if to say why aren't you under Mrs C, but I've never had a problem with Mr B, I've had three children with him, so if there is not a problem why fix it, I've had three with him and every time they ask why I'm not with Mrs C, he's never caused any complications. He takes good care and he allows his midwives to take quite a bit of care. He allows them to do all of the monitoring, he will fix me if need be"*

Carol (CLC, A/N, Multip: Transcript 2A,p4).

Carol's comments correspond with Shona's in relation to her identifying her children as Mr B's, placing trust in Mr B to take care of her through this experience or perhaps she is also an oncomouse, but with Mr B's trademark, instead of Mr D's. Carol views herself as disembodied; she views Mr B as her body fixer. Carol perceives the midwife as being under the control of Mr B, that the midwife is his handmaiden. She perceives the technology used for monitoring by the midwife as blurring into the main focus of her role through what she has witnessed, which is her situated knowledge.

The women experiencing midwifery led postnatal care were asked what they thought the doctor did, which was in contrast to what has been found above:

*"I haven't seen a doctor at all through my pregnancy; I have never felt I have needed to"*

Louise (MLC, P/N, Primip: Transcript 1A,p4).

*"I was happy with having midwifery led care, I was happy with that decision; I didn't need to see a doctor"*

Sarah (MLC, P/N, Primip: Transcript 1A,p4).

*"Doctors are supposed to be more educated, but the midwife explains everything to you. The Doctor said my baby was breech, I didn't worry, I just asked my midwife to check, she felt is as being head down and she explained what she was feeling where. She was right it was head down".*

Sarah (MLC, P/N, Primip: Transcript 1A,p4).

The midwifery led women appear to question the doctor's decisions, the need to see a doctor and ownership of their bodies. There appears to be a distinction between how the women' experiencing consultant led care and those receiving midwifery led care have come to know about the role of the midwife and about childbirth.

## **5.4 CONCLUSION**

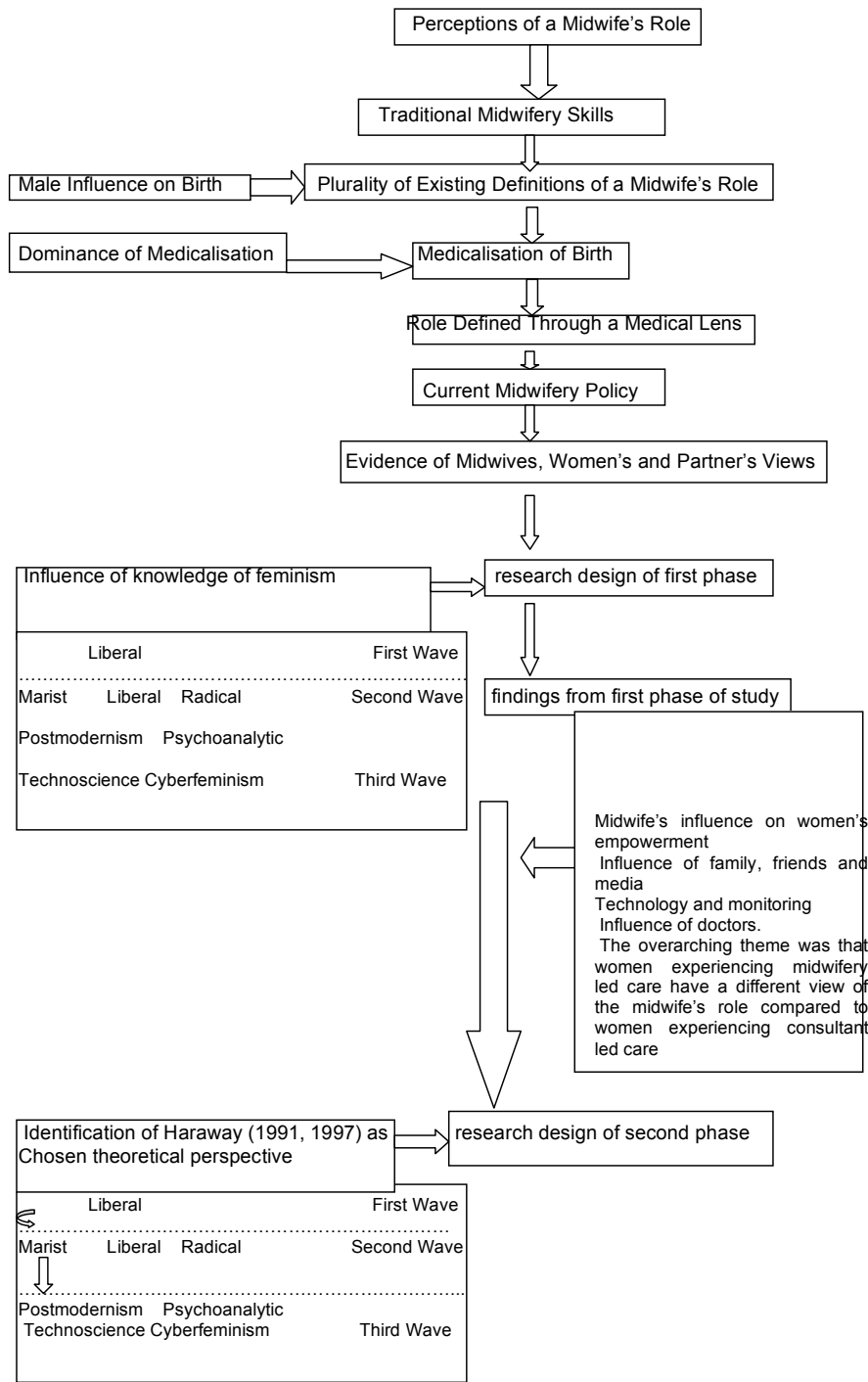
The first phase has suggested contrast between the 'situated embodied knowledges' of the women experiencing midwifery led care and those receiving consultant led care. Using Haraway (1988, 1991,1997) to interpret the findings of this phase has assisted my understanding of the women's current located knowledge.

The empowerment belief of women created by midwives provides a really interesting aspect, which only presented within the 'situated knowledges' of women experiencing midwifery led care. The influence of media appeared to be strong, especially within the midwifery led women's experiences, along with experiences of friends. Women who experienced consultant led care, were influenced by their family or previous childbirth experiences, if it was their first baby they were also influenced by the media. Women experiencing consultant led care appeared to come to know what a midwife did through their relationship with technology and monitoring, which was in contrast to the midwife's influence on women's empowerment, which was found within the 'situated knowledges' of the midwifery led women. The women's perception of the doctor's role in relation to the role of the midwife informed us of differences in the situated knowledges of women experiencing care led by different health care professionals. The women experiencing consultant led care perceived that the doctor is the decision maker within the relationship with her and the midwife. She views herself as disembodied. She sees the midwife as a handmaiden to the doctor, who integrates with technology to test her body and then reports the results to the doctor who makes the decisions about what interventions are needed to ensure her body functions in a timely manner. She is not connecting from the interactions from her body or baby from the inside, but coming to know about her body and baby from other factors around her, from the outside;

machines, midwives and doctors. Her experiences and observations have led her to her personal 'situated knowledges'.

The themes identified have provided useful information to guide this study into the next phase. In this chapter I have provided a partial perspective of women's perceptions of the role of the midwife. Further investigation is required to provide a deeper understanding. There has been an increasing body of evidence created more recently of women experiencing midwifery led care (Flint et al 1989, Page 1999, Sandall et al 2001, Walsh 2007a). Views from women experiencing consultant led care are not frequently investigated in comparison. The second phase of this research study concentrates on the situated knowledges of women receiving consultant led care. This is reflected with the midwife's views of how they think women perceive their role. This will provide the information needed to explore perceptions of the midwife's role further. In chapter 6 the findings from the second phase of this study will be discussed, and will provide a deeper insight into perceptions of the midwife's role. In chapter 7, I discuss the findings from both this and the second phase. Figure 5.1 tracks my research journey so far.

**Figure 5.1 Research Journey**



## **CHAPTER 6**

### **WHAT A MIDWIFE DOES: WOMEN'S AND MIDWIVES' 'SITUATED KNOWLEDGES'**

#### **6.1 INTRODUCTION**

This chapter presents the findings from the second empirical phase of this study. Data from the women's interviews, their diaries and the midwives' interviews are analysed and reported. As discussed in Chapter 4 data are organised into thematic networks to facilitate the structuring and depiction of themes (Attride-Stirling 2001). These themes are illustrated in figures 6.3 and 6.4 and the combined themes represented in figure 6.5. The data included in chapter 5 and 6 will be discussed in relation to the chosen theoretical perspective in chapter 7.

Firstly, the themes generated from the women's data, based on their 'situated knowledges', are briefly presented. The themes generated from the midwife's data, based on their 'situated knowledges' are also then briefly presented. However, one key component of the uniqueness of this thesis is the simultaneous collection of data from women and their midwives, therefore the main body of this chapter (section 6.4) compares and contrasts themes identified by these contemporaneous sources of perceptions of the midwife's role. Illustrative matched cases between women and their midwives are used, whilst a summary of the matched case for each woman and midwife can be found in appendix 3. These matched themes are then summarised prior to discussion in relation to Haraway's (1997) work on feminist technoscience in the next chapter.

#### **6.2 DEMOGRAPHIC DATA OF THE PARTICIPANTS**

I have organised the demographic data of the women and midwives into tables below. See figure 6.1 for the second phase relating to the women and figure 6.2 relating to the midwives. This provides useful background information to where the women and midwives are 'located', when considering the accounts of their 'situated knowledges'.

**Figure 6.1 The Women**

<b>Participant</b>	<b>Characteristics</b>
Terri	Lives in rural location Married Full time employment Local family support Age- early thirties
Denise	Lives on outer perimeter of town Married Full time employment No local family support Age- early twenties
Danni	Lives on outer perimeter of town Partner Part time employment Local family support Age- mid twenties
Fiona	Lives in densely populated area of town with parents. Partner Unemployed Age-late teens
Sally	Lives on outer perimeter of town alone Partner Local family support Full time employment Age- mid twenties
Isabelle	Lives on outer aspect of town with partner Local family support Full time employment Age- mid twenties
Jenny	Lives in densely populated area of town alone Partner Local family support Unemployed Age-late teens
Mel	Lives on perimeter of town with husband No local family support Full time employment Age- early thirties
Yvonne	Lives on outer area of town alone Partner Local family support Unemployed Age- early twenties
Amy	Lives in densely populated area of town with partner No local family support Unemployed Age- early twenties

**Figure 6.2 The Midwives**

<b>Participant</b>	<b>Characteristics</b>
Midwife caring for Terri	Qualified 5 yrs Experience in different birth settings, including midwifery led at other geographical locations. Currently working in consultant led birth environment
Midwife caring for Denise.	Qualified 6 yrs Worked within consultant led environment in same geographical location Currently working in consultant led birth environment
Midwife caring for Danni	Qualified 6 yrs Worked within a consultant led environment at different geographical locations. Currently working in consultant led birth environment
Midwife caring for Sally	Qualified 10 yrs Experience in different birth settings at different geographical locations. Recently transferred to a consultant led birth environment to a midwifery led environment.
Midwife caring for Fiona	Qualified 4 yrs Worked within a consultant led environment in same geographical location Currently working in a consultant led birth environment
Midwife caring for Issie	Qualified 6 yrs Worked within a consultant led environment in same geographical location Currently working in a consultant led birth environment
Midwife caring for Jenny	Qualified 10 yrs Experience in different birth settings at different geographical locations. Currently working within a midwifery led environment but occasionally works within a consultant led birth environment if there are staffing issues
Midwife caring for Mel	Qualified 3 yrs Worked within a consultant led environment in same geographical location Currently working in a consultant led birth environment
Midwife caring for Yvonne	Qualified 6 mths Previous job was as a maternity care assistant in a midwifery led birth environment at a different geographical location. Currently working in a consultant led birth environment.
Midwife caring for Amy	Qualified 12 yrs Worked within different birth settings in different geographical areas.



### **6.3 WOMEN'S THEMES: DISCOVERING WOMEN'S 'SITUATED KNOWLEDGES'**

The purpose of this section is to provide an overview of the women's themes, from their situated knowledges, organised through a thematic network analysis. The main global theme, three organisational themes (and related basic themes) are identified from the women's diaries and interviews (undertaken at 20-24 and 36-38wks of pregnancy, soon after birth and 6 weeks following the birth).

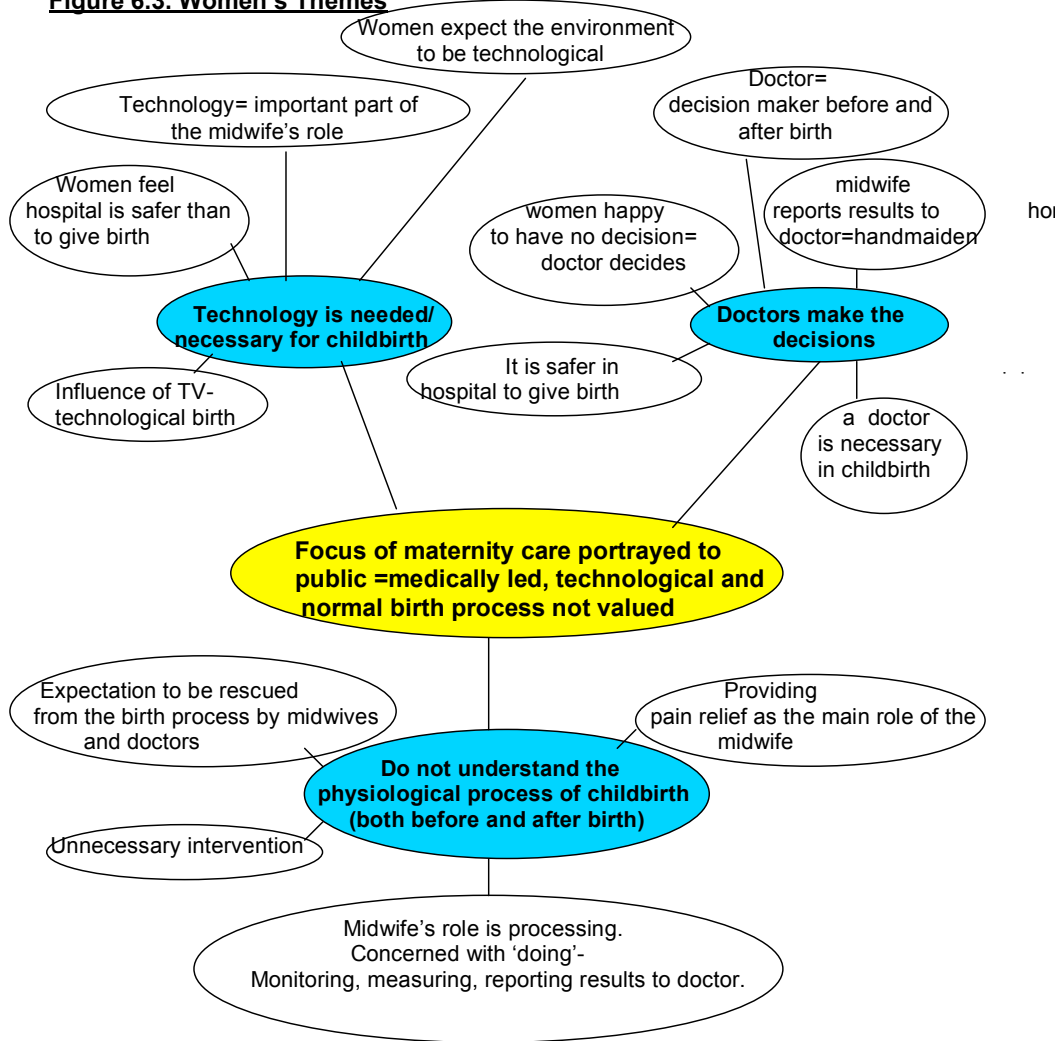
The three organisational themes (basic themes feed into these) identified are:

- Little or no understanding of the physiological process of childbirth;
- Perception that doctors make decisions during childbirth;
- Significant value placed on technology during pregnancy, labour and birth.

This provided an overarching global theme: the focus of maternity care portrayed to the public is medically led and technological, resulting in devaluation of the normal physiological birth process.

The global theme is central to the web of organisational themes and their related basic themes, which is shown diagrammatically in figure 6.3.

**Figure 6.3. Women's Themes**



Each woman will be positioned differently, depending on her own experiences and observations of the world. Themes identified are pulled together as similarities from the women's 'situated knowledges', while still recognising their own 'situatedness'.

### 6.3.1 Women Do Not Understand Physiological Birth

With the exception of Sally, all of the women throughout their interviews did not appear to be aware of the body's physiological function in relation to childbirth. This has implications for how women perceive the role of the midwife. The majority of the women perceived that they had no time to access education in relation to childbirth, even though they had been informed of how to access this. This may be related to some of my own assumptions that there are pressures on women to continue working for as long as possible, women do not view childbirth education as a priority in their lives, women want to disconnect themselves with this physiological process or women are not being informed about the process by midwives.

Here is an example from Fiona of how she has 'come to know' about the birth process and the role of the midwife:

*Fiona (36wks): "I went through the whole birth plan with R (midwife), so that was really good, she explained all of the different drugs I could have and stuff, so that was really good because I did not have a clue what I could have. I was told about classes at the children's centre up the road, but I haven't got the time to go to any...I learnt a bit from R (midwife) when we discussed the birth plan, but we didn't have much time, and also from friends and my family.....I found out that it is painful and just to go with what they say and have anything they will give me for the pain"*  
(Transcript 14, p2).

The information given by the midwife was perceived as structured around the need for pain relief in normal labour and birth. Fiona was sign posted by the midwife to access further information, but this was not accessed.

The findings show that women favoured the convenience of intervention and medicalisation as an accepted option for birth<sup>43</sup>. Prior to the birth the women did not acknowledge any pain or trauma experienced with this option and appeared unaware of complications, which may occur. The convenience of knowing when the birth would take place had a high priority.<sup>44</sup> The majority of the women appeared to be reliant on the use of pain relief in labour, rather than knowing how to use their body optimally to deal with the physiological process birth offers. They wanted to engage with the medical model. This suggests a perception that the medical culture will do the 'right thing' by them and this is

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<sup>43</sup> See section 6.5.1

<sup>44</sup> See section 6.5.1

accepted as being 'just how it is'. I have used longitudinal transcripts from Amy to demonstrate the major discoveries in this section, so that it is possible to have some insight into how Amy 'came to know' about labour, birth and how these feed into her perceptions of the role of the midwife. I asked Amy about her expectations of labour and what she knew about birth:

*Amy (20wks): "no I don't really know not yet, I hope to know before I have the baby though"*  
(Transcript 37,p1).

*Amy (36 wks): "I've seen lots of programmes on the telly (television). I expect the pain will be awful, so I want as much pain relief as possible... I just want an epidural and have it over with as soon as possible...I have not had time to go to any sessions about it with the midwife"*  
(Transcript 38,p2).

*Amy (following the birth): "It was awful, I was in so much pain, I just wanted them to take the pain away so I had an epidural. The doctor said I wasn't dilating so I went for a caesarean. The midwife was lovely, but she wanted me to move around and I just wanted to stay on the bed, I was in too much pain to move. I just wanted them to make it stop, I wanted them to take it all away and for me to be normal again, it was awful"*  
Transcript 39,p3).

Amy felt that the main role of the midwife was to provide pain relief:

*Amy (36wks): " she will give me something to help take away the pain and if I can't do it to tell the doctor, who will let me have a caesarean. That happened to my friend, she was so tired and fed up that she asked the doctor if she could have it out and over with and he said she could have a caesarean"*  
(Transcript 38,p2).

*Amy (6wks following the birth): "I do think that you need a midwife but she didn't want to give me anything for the pain, she wanted me to try using the pool and tried to get me to walk about, but as soon as I saw that bed, I was on it and didn't want to move. I was disappointed that she didn't get me an epidural sooner. I just wanted her to make it stop, but she just sat there feeling my tummy and watching me a lot of the time to start with, she didn't seem to be doing anything. She was lovely though and did sort out an epidural eventually"*  
(Transcript 40,p4).

Amy appears to expect to be 'rescued' from the birth process. She does not want to connect herself with her body to experience the process of labour and birth physiologically, suggesting disembodiment. Martin (1987) describes this

as happening during labour; this study suggests this could be a psychological effect prior to the birth.<sup>45</sup>

This organisational theme is built from the basic themes feeding into it. In this section they are:

- Midwife's role is processing. Concerned with 'doing': monitoring; measuring; reporting results to doctor.
- Providing pain relief is a main role of a midwife.
- Expectation to be rescued from the birth process from midwives and doctors.
- Unnecessary intervention.

Interactions with the midwife throughout their childbirth experience show that the interpretation of the midwife's role is concerned with processing and 'doing'. This is based on the midwife 'doing' things 'to' or 'for' the woman. It includes measuring, monitoring, testing and weighing. Usually machines are used to do these tasks. Women observe midwives interacting with technology on a regular basis, therefore perceiving this to be an important part of their role<sup>46</sup>. This was 'situated' as a principle function of the midwife by all of the women in the study, throughout their childbirth experience. This is demonstrated longitudinally in Fiona's interviews and diary.

I asked Fiona what role she thought the midwife had:

*Fiona (20wks): "her job is to check on my baby and the growth of it"*  
(Transcript 13,p1).

*Fiona (36wks): "at the hospital they were just monitoring, they measured my tummy and did his heart and stuff and that was about it".*  
(Transcript 14, p2).

*Fiona (following the birth): "they were monitoring and listening to the monitor of his heart...she checked the heart rate on the monitor and that. I think it was for contractions as well. When I had the Pethidine I was going to sleep and I was scared in case it was affecting him, when she checked his heart rate it was okay, it reassured me so much...the most important part of her role was to watch his heart rate and stuff and make sure he was okay"*  
(Transcript 15,p3).

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<sup>45</sup> See section 6.5.1

<sup>46</sup> This is discussed in more detail when matching women's and midwives themes in section 6.4.

*Fiona: " the midwives in the hospital and the community midwife they both check the baby and measure me and stuff, but there are doctors at the hospital who they need for the decisions"  
(Transcript 16,p4).*

*Fiona's diary (28wks) "the midwife measured my bump which measured fine. She checked the heartbeat, which sounded okay and found easily. She took my blood for some tests and checked my blood pressure".  
(Diary 4,p1).*

These activities of the midwife generally involved the use of technology, which demonstrated to the women the importance of it in current consultant led maternity care and to the role of the midwife. The diaries also reflect a symptom of processing, the waiting time experienced for appointments to see midwives at doctor's surgeries and hospital antenatal clinics, this resulted in dissatisfaction and places a greater emphasis on this being an essential function of the midwife's role.

At a time when women are just adjusting to the life changes they are having to make, the system seems to burden them with testing and all of the abnormal complications that can occur, making them fearful of the whole process, which will become their situated knowledge. It becomes an abnormal and technology focused world, taking their mind and spirit away from the natural and the normal. The focus of the midwife becomes concentrated on the abnormal; the woman observes this. Following the birth of the baby, women continued to see monitoring and measuring as a priority in relation to the midwife's role.

Through the interactions with their midwives, the majority of the women interpreted her role as a 'gatekeeper' for pain relief throughout their experience. Expectations of labour during their pregnancy were that they would require pain relief, as shown in Yvonne's interviews.

I discussed with her what she thought the midwife did:

*Yvonne (36wks): "in the hospital the midwife will be busy with everything I expect...she needs to sort out the drugs and things for my pain relief and they have to watch that monitor thing to make sure the baby's heartbeat is okay. I will really need my partner at my head end helping me"  
(Transcript 34, p2).*

*Yvonne (following the birth): " she was lovely. She gave me pain relief when I wanted it; she gave me Pethidine and explained what she was doing. Except,*

*she tried to get me to stay in the one position, but I said I wasn't comfortable so she allowed me to move"*  
(Transcript 35,p3).

Yvonne's comment about the midwife 'allowing' her to move is interesting, as she must view the midwife as having authoritative knowledge over her own knowledge of what position she wants to be in herself.

Women were also influenced about pain relief during their experience in labour, as demonstrated in Isabelle's interview below:

*Isabelle (following the birth): "I wasn't going to go for an epidural, but it was going on for so long that the plan changed, she told me to have it. I thought about it in there, as I didn't really before hand...pain relief is her role "*  
(Transcript 23,p3).

Amy, Yvonne and the majority of women in this study want to have pain relief and perceive the provision of this as a major function of the midwife's role. Isabelle and Jenny interpreted that the midwife influenced them to have pain relief. Here is an example from Jenny's interview:

*Jenny (36wks): "the midwife is there for me if I need anything, I will need her to give me something for the pain.....the midwife just talked about pain relief when we did the birth plan, I didn't manage to get to any classes"*  
(Transcript26, p2).

Another influence is the media, which generally shows medicalised models of pregnancy, labour and birth, which contribute to what women also view as important aspects of the midwife's role. This is discussed in relation to the findings in section 6.5.1.

The majority of the women felt the role of the midwife and doctor was to rescue them from this physiological process at the 36 week gestation interview and following the birth interview. Here is an example from Isabelle:

*Isabelle: (following birth): "I just wanted the midwives and doctors to rescue me from it. I just wanted it over with really and the pain taking away...I felt it was the midwife's job for pain relief and to make it stop"*  
(Transcript 24,p4).

The need for wanting to be rescued appears to be a symptom of not understanding the birth process, as the women who expressed this need did not appear to have accessed information in relation to the normal physiological birth process and did not connect their body to themselves, but relied on pain

relief, midwives and doctors to stop the normal physiological process. They did not want to engage with the process. Amy and Terri demonstrate these points:

*Amy (following the birth): "I do think you need a midwife, but she didn't want to give me anything for the pain, she wanted me to try using the pool and tried to get me to walk about, but as soon as I saw that bed, I was on it and I didn't want to move. I was disappointed that she didn't get me an epidural sooner. I just wanted her to make it stop, but she just sat there feeling my tummy and watching me a lot of the time to start with, she didn't seem to be doing anything. She was lovely though and did sort an epidural eventually"*  
(Transcript 39,p3).

*Terri (36wks): "I know that having a baby is painful and I want to get it over with as soon as possible. I don't really think we should have to go through it, why can't we just have a zip instead and just carry on like normal? Even if we knew when it would happen it would be so much better so we could plan things"*  
(Transcript 2, p2).

Two women following the birth, discussed how intervention was a fundamental part of their midwife's role, under direction from a doctor. In the majority of cases women are led to believe that intervention will shorten the process of labour, which appears to be an objective within this environment. This is demonstrated by Jenny's experience:

*Jenny (following the birth): "when I was in labour she (the midwife) was in and out, quite a few people were coming in and out to see if I was okay; consultants and stuff like that...  
The one, the consultant came in, there with about six of them and they said that the baby was ready to come and that they had to break my waters and stuff. He explained everything that the midwife was going to do and that.... She said the baby was ready to come out but my waters weren't breaking or something like that. When she did it she said that the baby would be out in ten minutes and I would be okay. She then put me on a drip. She was really good, they all were, but it was hours before it was over"*  
(Transcript 27,p3).

Intervention can lead to an operative birth and can create complications (NICE 2007), but this evidence was not discussed, a favourable perspective of intervention was given. The women did not question why the intervention would be necessary or asked if there was any evidence to support the intervention. Davis Floyd (1997) describes how medical knowledge is viewed as the authoritative knowledge within the environment or model of care, which suppresses other knowledge from other participants, including the midwife and the woman. There appears to be an acceptance that medical knowledge is superior within the data and an acceptance that health professionals will 'do the



right thing'. Women accept intervention and the perceived authoritative knowledge of the environment they find themselves within.

### 6.3.2 Doctors Make the Decisions

Four basic themes feed to the organisational theme, relating to doctors who, are perceived as making the decisions by the women in this study.

The basic themes are:

- Doctor is the decision maker throughout childbirth experience
- Woman views midwife as handmaiden (midwife reports results to doctor to make the decisions)
- Doctor is necessary in childbirth
- Women feel safer in hospital (doctor's presence)

Nearly all of the women perceived doctors as the decision maker regarding their care. This was evident longitudinally through their interviews and diaries.

Most of the women said the doctor told her what was happening when her care was planned and accepted this. As in section 6.2.1 it appears that women 'come to know' that the medical culture will do the 'right thing' by them and this is accepted as being 'just how it is'. This shows that within this model and environment, doctors are viewed as having power and control over the decisions made. They are perceived as having knowledge that is valued. Jordan and Irwin (1989) argue that most women willingly submit themselves to the authority of the medical view.

*"They manage to experience the technologies and procedures as reassuring and the delegation of authority to physicians as functioning in their own.... best interests"*  
(Jordan and Irwin 1989:20).

This belief is echoed longitudinally in the findings from this study, here is an example from Fiona's interviews:

*Fiona (20wks): "I do what the midwife tells me, she knows best"*  
(Transcript 13,p1).

*(36wks) "the doctor will be in the room he will tell me how I'm going to have the baby"*  
(Transcript 14,p2).

*(following the birth): "the doctor made the decisions about my care, the registrar"*  
(Transcript 15,p3).

*(6wks following the birth): "When I was having her she (the midwife) would tell the doctor what was happening and it was the doctor who made the decisions about what would be happening to me."*  
(Transcript 16,p4).

Most of the women at 36 weeks of their pregnancy and following the birth described the midwife's role as being a 'handmaiden' to the doctor, who passes on the results of testing for him to interpret. Within this culture the midwife is perceived as being subservient. Here is an example from Terri's interview following the birth:

*Terri (following birth): "there was a midwife in theatre, but she was like a blur, rushing around everywhere, doing what she was told.... the doctor was operating and I couldn't really see, but I suppose he told her what he wanted her to do beforehand"*  
(Transcript 4,p3).

The 'situated knowledges' gained by the women perceived that the midwife is unable to function on her own. This leads to the conclusion that midwives are not viewed as autonomous practitioners, but functioning under direct supervision of the doctor, as handmaidens. The majority of the women said at, least at one of their interviews that a doctor was necessary in childbirth. Interestingly the majority of women perceived that a doctor would be present at the birth of their baby.

Jenny discusses her perceptions:

*Jenny (20wks):" the doctor tells the midwife what to do"*  
(Transcript 25,p1).

*Jenny (following birth): " I needed a doctor to instruct the midwife to break my waters and he explained it in a bit more detail"*  
(Transcript 27,p3).

Two of the women at 36 weeks of their pregnancy or following the birth, perceived the midwife's role as being a communicator between her and the doctor. In a positive aspect the woman is using the midwife as her advocate. Alternatively, it can be interpreted that she is not able to communicate with the doctor directly. She values her knowledge and feelings as insignificant. The doctor has the authoritative knowledge within this model of care/environment. The legitimising of one way of knowing as authoritative often leads to devaluation of all other ways of knowing (Jordan and Irwin 1989).

Here is an example from one of Sally's interviews:

*Sally (36wks): "when I went in the doctor wasn't speaking to me, she was talking to the midwife, but didn't say anything to me. The midwife was like the link she explained everything after the doctor had gone"*  
(Transcript 18,p2).

In this example, the midwife is also viewing the doctor's knowledge as authoritative, as she does not ask the doctor to explain himself to the woman if she failed to understand, she waits until the doctor has gone before explaining to the woman. The woman observes the midwife behaving in this manner and these form part of her 'situated knowledges'

The women were aware that part of the midwife's role was to provide the option of having a homebirth. The majority of the women, at different time points, thought that the hospital rather than the home was a safer place to have their baby. The reasons given for this were that technology and doctors are available in the hospital and not at home. The women in the study interpreted these two factors as making birth safe.

*Denise: "I knew that I wanted to have my baby at the hospital...I think with your first baby that if something went wrong you know (pause), because I'm not sure what will happen because it's my first you know. I just feel a lot safer being in the hospital than I would at home, because there is technology around me. If anything was to happen there are doctors there as well. I think it's just the whole thing, technology and doctors being there that makes me feel safer"*  
(Transcript 6,p2).

The women perceived hospital birth as safer than homebirth. Through their childbirth experience women have witnessed midwives using technology, and discussing abnormality of childbirth through offering testing for various abnormal conditions. They have observed midwives' interactions with doctors, where the doctor is perceived as having the authoritative knowledge. Therefore women perceive that midwives are unable to function without technology and doctors and perceive birth in a hospital environment to be safer than that at home. Only Sally felt safe with a midwife and would have a homebirth next time. Sally's interviews throughout resonate with the midwifery led women's perceptions of the midwife's role in the first phase of this project.

### 6.3.3 Technology is Necessary/ Needed in Childbirth

Basic themes feeding into this are:

- Technology is an important part of the midwife's role.
- Hospital is safer than home to give birth.
- Expect environment to be technological.
- Influence of television programmes (show technological birth).

Significant value was placed on technology during pregnancy, labour and birth. This emerged from interactions with midwives that shaped their views of the midwife's role. In particular, the use of technology for monitoring by the midwives, as discussed earlier in this section. On further investigation this theme ran through their experience, from the first to the final interview. This example from Jenny shows how she interprets the midwife's reliance on technology within her role and how Jenny felt safe being attached to the monitor:

*Jenny (6wks following the birth): "when I was in labour there was a midwife and two others to check to see if the baby was okay on the monitor, they were so good, they were lovely. About every five or ten minutes she kept going out and coming in and going out and coming in. Then checking the heart monitor first, then checking the pains on the monitor and asking me if I wanted more pain relief. She was really nice. I felt okay when she wasn't in there, I was with my mum and my boyfriend, I felt fine and she was in every five minutes and I had the alarm if I needed her I only had to press it"*  
(Transcript 28,p4).

This demonstrates how technology is used by the midwife to replace her or as a baby minder.<sup>47</sup>

The midwives are working within this technocratic medicalised birth culture and must conform to be accepted, this ensures they keep their employed status within the institution. Encouragingly, all of the women in this study perceived that a midwife was needed throughout their childbirth experience. An interesting aspect to these results, found at the initial interview, was that most of the women perceived that the midwife would be with them all of the way through their childbirth experience. Through the woman's experience their 'situatedness' would change and their situated knowledge developed. Where they were 'situated' was different for each individual woman. Some women were disappointed that they did not experience continuity from the same midwife in the interviews following the birth of their baby. Some women expressed that

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<sup>47</sup> This is discussed further in 6.5.3

they did expect continuity during their pregnancy, but following the birth said that they had not expected this to occur, which was a contradiction to their previous response. A few of the women did not think continuity was important throughout their childbirth experience, but did only expect to see a few rather than many midwives, therefore still valuing some level of continuity. These findings seem to reflect the importance of this for women.

All of the women throughout their experience, valued the support of family/partner through their childbearing experience. They felt this gave them support and advocacy. An important finding in relation to this is that about half of the women described being without their family/partner through their experience as being on their own. As a midwife the role should be primarily to support women and to be their advocate, this function was not perceived as being part of the midwife's role.

Providing an appropriate environment for birth was perceived as part of the midwife's role. Only a few of the women described wanting to have a calm, comfortable environment; the other descriptions are of clinical high technological environments being provided for birth. Some of the descriptions are barbaric in nature and are full of visions of fear and pain.<sup>48</sup> The most interesting perception is that of having machinery with them in the room, as this is an accepted vision and it appears to be a wish that technology is there. This correlates with the perception of the midwife needing to use technology to function in her role. The women expect the midwife to use a mixture of technology and sharp instruments in labour and birth as part of her role. Here are some examples of the expectation of what will be in the labour room:

*Danni (36wks): "a drip, the machines to monitor me, a doctor, the midwife and my husband"*  
(Transcript 10,p2).

*Mel (36wks): "me and my husband, a bed and lots of machines I suppose and those silver trolleys with knives and scissors and things on them"*  
(Transcript 30,p2).

How childbirth is portrayed within the media appears to have an effect on women's views of the role of the midwife. Television programmes had a

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<sup>48</sup> See section 6.5.1

considerable influence on perceptions of the midwife's role in this study. Most of the women at 20 weeks or 36 weeks of their pregnancy interpreted television as influencing their perception. Celebrity stories of childbirth also had an impact on this. Here are some examples from the women's interviews of the responses when I asked if they knew what midwives did before they were pregnant:

*Yvonne (20wks): "just from magazines and television programmes really I suppose. You tend to get celebrities talking about pregnancy and labour and things now. They always look so glamorous afterwards don't they? I hope I'm like that. Posh had her toenails painted when she had one of hers I think, do you think they would do that for me? (laughing)"*  
(Transcript 33, p1).

*Terri (20wks): "only from family and the telly. On the telly it's usually about when you are in labour, it just looks technical and scary"*  
(Transcript 1, p1).

#### **6.4 MIDWIVES' THEMES: MIDWIVES' KNOWLEDGE CONSTRUCTION**

This section provides an overview of the main global theme, three organisational themes and related basic themes identified from interviews with the midwives who were present either in labour or/and at the birth of each of the women's baby's. Ten interviews were performed, within four weeks of birth. The midwives are identified as each woman's midwife, throughout the text.

The three organisational themes identified were:

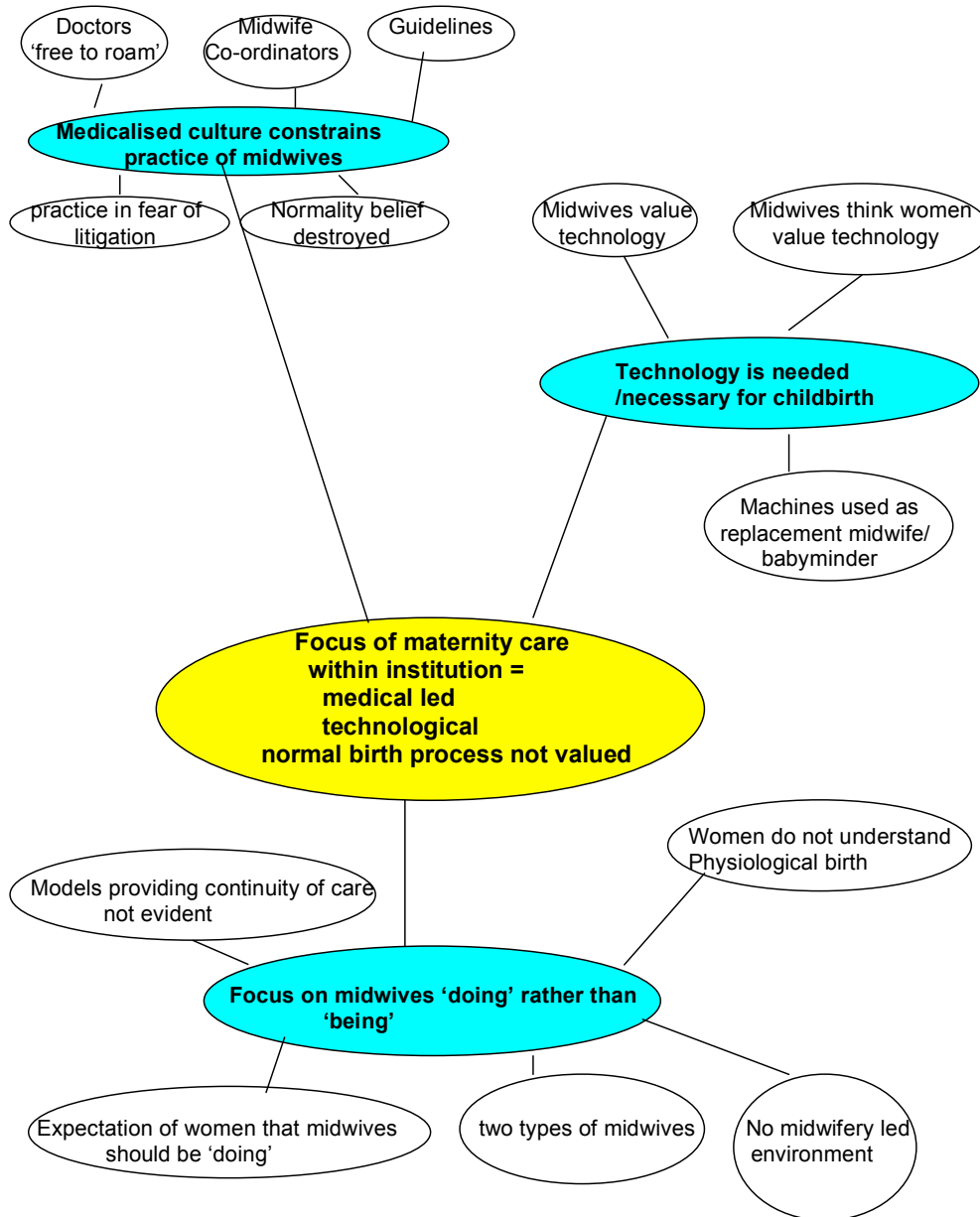
- Focus on midwives 'doing' rather than 'being'.
- Medicalised culture constrains practice of midwives supporting normal physiological process, which is influenced by dominant medical discourse.
- Significant value placed on technology during pregnancy, labour and birth.

This provided an overarching global theme, which is similar to the one identified in relation to women's themes: the focus of maternity care within the institution is medically led and technological, which has resulted in devaluation of the normal physiological birth process.

The global theme is central to the web of organisational themes and their related basic themes, which is shown diagrammatically in Figure 6.4.

The basic themes are discussed within each organisational theme in the next part of this section. It may be beneficial to refer to Figure 6.4 whilst reading the next part of this section.

**Figure 6.4 Midwives Themes**



Midwives will be 'situated' differently depending on their own individual experiences of life, including those of being a woman and as a midwife. Their 'situated knowledges' are individual, but do relate to some identifying themes to colleagues working within the same model of care and environment. Grouping themes together can result in losing some of the midwife's 'situatedness', although I have attempted to retain this.

#### **6.4.1 Focus is on Midwives 'Doing' Rather Than 'Being'**

The basic themes feeding into this organisational theme are:

- Expectation of women that midwives should be 'doing'.
- Women do not understand physiological birth.
- Two types of midwives.
- Models providing continuity of care not evident.
- No midwifery led environment.

Two of the midwives interpreted that women expected midwives to be 'doing' something to them, perceiving that women were unaware of the value in waiting and watching skills, which I will call 'being'. This finding correlates with the women's expectation of the midwife's role, as women perceived the midwife's role as 'doing'<sup>49</sup>. 'Doing' is based on the midwife 'doing' things 'to' or 'for' the woman. It includes processing by measuring, monitoring, testing and weighing; usually machines are used to do these tasks. 'Being,' on the other hand, is based on midwives using 'watching' and 'waiting' skills, valuing traditional midwifery practice. 'Doing' skills can be interpreted as obstetric nursing, while 'being' skills nurture the natural and normal philosophy of midwifery. 'Being' midwives enjoy 'low risk' care, practicing in a normal philosophy of birth. 'Doing' midwives, enjoy practicing 'high risk' care, practicing in a technocratic medicalised philosophy of birth based on a scientific biomedical paradigm. Most of the midwives in this study want to be 'being', but are prevented from providing this type of care, as they perceive the women and the culture they are working within expect them to be 'doing'. A few of the midwives wanted and enjoyed 'doing'. One of the midwives enjoyed both 'being' and 'doing' but interestingly when I discussed how she thought women perceived her role, she

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<sup>49</sup> Discussed in chapter 5



described to me all of the things that she would do. She thought that I wanted to know that she was 'doing' rather than 'being', that the woman's perceptions of the role would be about what the midwife was 'doing'.

Midwives all agreed that there were two types of midwives. The findings show that the culture supports midwives practicing in an obstetric high risk model rather than practicing supporting normal physiological birth within the labour ward environment. The midwives are able to identify themselves or colleagues in either category. Here is an example from the midwife caring for Jenny's interview:

*Midwife caring for Jenny: "in my opinion there are midwives and obstetric nurses. Midwives who are brilliant at supporting normality, but also know when to move in if there is a problem and you usually find those midwives don't get any problems because they are less likely to use any intervention when its progressing normally. You usually find the ones who don't get the problems are those that keep their hands to themselves and don't interfere with the normal process and let it do its job...unfortunately these midwives migrate, because they feel suppressed, alienated and ostracised. They are fearful for their own reputation really. They think rather than work outside what everyone else is working in then they will go and work in a place they can practice how they want with others practicing in the same way. If they stay on the labour ward they are going to loose what's sacred to them, their own belief systems. They need to go away to save their belief systems. I know what I believe in I can't protect on there. Anyone who is a true midwife will move away from there to protect themselves and their belief systems"*  
(Transcript 47,p2).

The majority of the midwives felt that they needed to be able to work in an environment conducive to normal birth and expressed wanting to work in a midwifery led environment. Here are some examples:

*Midwife caring for Mel: " I think it's difficult working in the way we do to build up a good relationship"*  
(Transcript 48,p2).

*Midwife caring for Sally:" Yes we are constrained because there are not enough of us. There is not the flexibility in the way we work. If we got to know the woman first it would be a huge bonus. In community you knew her before you delivered her so you did get to know them antenatally and you could support them better postnatally so you knew who they were and they knew you too. But, in the unit you have no idea you can't build a relationship in two minutes, its horrible.....I did work on the old midwifery led unit, when we had one for a few years. Our culture was that everything was normal until proved otherwise. Now in this consultant unit the tendency is every thing is abnormal till proved otherwise and it really was a big eye opener and I think if we could get that culture back we would start to trust the natural and the normal again"*

(Transcript 44,p2).

Two of the midwives did not interpret working within a model providing continuity to women as beneficial. Issie's midwife expressed how providing continuity can provide disadvantages for them, as they would have to continually give care to women they have found to be difficult to care for:

*Midwife caring for Issie: "Definitely, but in the same breath they are hard work and so I will pass the buck and not take the lady because I was up here last night and although I know what's going on I don't want her to drain me anymore you know"*  
(Transcript 42, p2).

The majority of the midwives interpreted that women did not understand normal physiology of childbirth, therefore, did not understand the role of the midwife. They perceived women to be unaware of the normal physiological function of their body in labour and birth. They identified that women expect to be rescued from the pain of childbirth, rather than believing in their body and working through the physiological process. There is observed detachment of the woman's self from her body in these accounts. They also acknowledge that midwives support this detachment by supporting the 'rescue', rather than helping the woman through the process physiologically. The midwives caring for Amy and Jenny demonstrate these points:

*Midwife caring for Amy: "I think there is lack of understanding about birth, I am sure a lot of misinterpretation comes from TV programmes. They (women) think it's going to be really easy and really quick because of what they see. They seem to expect we are going to take all of the pain away, like they haven't got a job to do themselves, that we will rescue them from it"*  
(Transcript 50,p1).

The midwife caring for Jenny recognises that midwives support and instil the 'rescue' belief:

*Midwife caring for Jenny: "Midwives now see epidural as normal. There are now very few midwives that facilitate normal childbirth, that nurture and cherish women and make them feel positive and able to cope with the process of birth because the skills have now been lost and epidural is seen as normal in the process of having a normal birth. We need women to believe in themselves, not rely on epidural. By women not having that belief it makes their pain threshold much lower"*  
(Transcript 47, p3).

#### 6.4.2 Technocratic Medicalised Birth Culture Constrains Practice of Midwives

The basic themes, which make up this organisational theme, are:

- Doctors are 'free to roam' .
- Midwife Co-ordinators influenced by medical decision making.
- Guidelines support obstetric practices.
- Midwives practice in fear of litigation.
- Belief in normality is destroyed.

All of the midwives interpreted a medicalised culture on the labour ward. The elements that they thought influenced the culture are: doctors; midwife co-ordinators; guidelines; normality belief destroyed; the birthing room layout; and fear of litigation.

All the midwives acknowledged that doctors influenced the culture on the labour ward. Most of the midwives had protected women from receiving unnecessary intervention by not allowing the doctors into the room unless they determine it to be necessary (if labour is not progressing normally). Due to the labour ward environment being viewed as medically dominated, doctors see no boundaries and assume responsibility for the care of all the women accommodated there, doctors are 'free to roam'. The midwife caring for Amy discusses this concept:

*The midwife caring for Amy: "On the consultant labour ward they assume care of all of the women. They assume all of the women are their responsibility. So we desperately need a protected space for normal birth to happen, it would be great to have a midwifery led unit"*  
(Transcript 50,p1).

Midwives comply with the technocratic medicalised birth model:

*The midwife caring for Danni: "when a doctor comes into the room they always thank the doctors. They (women) make you feel like you haven't done anything, like the doctor has done all of the care even though I've been with her for hours. All they see is the doctor... when they get involved there is more intervention because of these damn time limits. I know for a fact that if we were to give them extra time they would do it"*  
(Transcript 43,p2).

The doctors and the midwife co-ordinators ensure the labouring women are processed through 'stages', with a timescale for completion of the product (Walsh 2007). The findings reflect this model existing within the labour ward environment. The midwife co-ordinator is a manager of the production line,

ensuring the repairers (doctors) are given access to the production line, to ensure continuation for maximum production. The function and culture of the labour ward contribute to the perceptions women gain of the midwife's role.

A few of the midwives interpreted that within this culture midwives practice in fear of litigation. They identified that this led to a mechanistic model, used to process women through the labour ward, ensuring midwives did the correct monitoring and measuring via a regulatory framework, as described by Walsh (2009). The midwives in this study felt that this kept them away from 'being with woman', the role they want to do. Guidelines support this regulatory framework. Midwives feel guidelines and new policies have increased medicalisation and feel they have restricted their practice. All of the midwives interpreted guidelines as supporting medicalisation of birth, which pulls midwives into practicing within a mechanistic model. Midwives are fearful to practice outside these rules. The midwife caring for Denise demonstrates this:

*"I think you are really restricted by the guidelines, much more than we used to be...with technology they all have their place, but a lot of it is unnecessary use of technology. It seems to be that we have functioned perfectly well on our own for years and years and then you get one problem with one person and then it's just a blanket policy across everyone. The system is really reactive, it is not seeing women as individuals anymore it's just a blanket policy across everyone. Your credibility and experience is not taken into account, your judgements for making decisions is not taken into account, they tell you what you are to do and you have to follow them"*  
(Transcript 42, p2).

The culture on the labour ward appeared to change the belief the midwife had in normality, according to most of them who were interviewed. Midwives discussed how they felt coerced into conforming to the medicalised culture, which exists within this environment. The most distressing of the findings is that the midwives who are trying to protect normality are being driven out of the places that need to change because they express how they are unable to fight against the dominant discourse, which clearly exists, see section 6.4.

The findings disclose that midwives who have previously worked within a midwifery led environment found conflict with the ideologies of the consultant led labour ward culture. The midwives felt that this does have an impact on junior midwives working within this environment and felt that they are more

likely to comply to the demands of the 'technocratic medicalised birth machine', dictated by the health professionals supporting this culture:

Midwife caring for Sally: "When I was training things were less restricted. I have got the experience, which I can rely on. Junior midwives have not got that and they have grown up in this restricted culture. Their expectation is that things will have to be done that way to survive and because they haven't got the experience, they do it. I think we have got to support the girls that have just qualified. I think it becomes a culture to call a doctor for anything, I can understand why, it's frightening and they haven't got the experience or the confidence. They have also been raised in the culture they are in, an interventionist one, the culture is certainly not real midwifery, and it is dominated by medicalisation"  
(Transcript 44,p2).

Bullying has also been a reason for midwives to leave the profession (Ball et al 2002). The midwives in the study talked frankly about their experiences of fighting against the medical discourse and may be at a high risk of leaving the profession.

*Midwife caring for Sally: "I don't enjoy not giving proper care to women. I worked on community for ten years and out there you do give care, still not as good as you would like to due to time constraints due to staffing but it is easier to work as a midwife. You still have guidelines, but there is nobody looking over your shoulder to say, "you have not done this" or "you have done this". I know by definition the women are low risk generally so things don't seem to escalate so much, but the difference working in the unit is you feel yourself being unable to fight against the system and having to comply to it.*

*I have got a lot of years experience of being out there in community, on my own quite happily, only calling in when I need them, but even I feel that I have to comply to the culture in there. At the moment but I am not sure how long it will be before they grind me down totally"*  
(Transcript 44,p4).

Midwives interpreted paperwork and staffing levels as restricting the time midwives could spend with women, which supports the mechanistic model prevalent within this environment.

The underlying explanation for the medical discourse being dominant is that midwives perceive doctors as making the decisions. All of the midwives thought that women think that doctors make the decisions about their care. Some of them perceived this because women do not witness midwives functioning in the role they thought they were trained to do. The way they work is dominated by the obstetric culture. There is evidence within this study that midwives bring this

perception to women themselves with their actions within the hospital environment.

The midwife caring for Terri discusses this:

*Terri's midwife: "doctors, always doctors. If you think something is wrong then you go and speak to the doctor and I think that they always think that you are going out to speak to the doctors when you go out the room and so they think that doctors make the decisions about everything"*  
(Transcript 41,p3).

The reason for this is they are complying with the 'rules' of the big 'technocratic medicalised birth machine' and so feel compromised to behave and practice within an obstetric ideology. The doctors are the 'modest witnesses' of the 'technocratic birth machine', for midwives to survive they have to comply to the symbolic order laid down by the 'modest witnesses' of the 'technocratic medicalised birth machine', therefore becoming modest witnesses of it themselves.

#### **6.4.3 Significant Value Placed on Technology in Pregnancy, Labour and Birth**

- Value technology.
- Women value technology.
- Machines used as a replacement midwife/ baby minder.

Some of the midwives felt the birthing rooms posed a problem to promoting normal labour and birth. The women are compelled to conform to the discourse they are within. She surrenders herself to the 'technocratic medicalised birth machine' that she believes is promoted and supported by the midwives<sup>50</sup>.

Midwives identified that they are unable to provide one to one care on occasions and will use technology to replace themselves. The majority of the midwives felt that machines were used as a 'baby minder' or to replace a midwife. Reliance on technology is viewed as acceptable within this environment<sup>51</sup>. The findings from this study show that midwives do value technology in childbirth and the usage of it being part of their practice. It also shows that some midwives prefer to use it and others only use it if it is

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<sup>50</sup> See section 6.4

<sup>51</sup> Refer to section 6.4.3

necessary. When discussing the use of technology with the midwife caring for Fiona she said:

*“Yes it’s good for me definitely”*

When we were discussing how she thought women viewed technology she said:

*“A woman always wants her baby safe”*  
(Transcript 45,p2)

She appears to be specifically relating the use of technology as having the ability to make pregnancy and birth safe.

The findings show evidence that the labour ward culture supports the use of machines and technology, even when they are not needed in the birthing rooms. The midwife caring for Amy discusses this:

*“ Midwives tend to use technology just in case. If you start using one it’s impossible to get it back off. If you just listened in with the pinnard it’s just so lovely, they are free to move around and it’s just so natural. I think technology is the slippery slope into making things medical instantly, especially the CTG. With litigation now midwives are afraid not to use them, so they will use them just in case because if they hadn’t done one and something went wrong, then they will get blamed for it being there fault because they hadn’t done it. A lot of the time the coordinator will tell them to do one even if there is no indication, but just because the woman is experiencing consultant led care. It’s about covering your back and its getting worse. It’s all litigation based now, you’ve just got to cover yourself now, that’s seen as the most important thing, rather than the care we give. It’s horrible”*  
(Transcript 50,p2).

The midwives expressed that the technical skills of using machines and obstetric values and practices are viewed as the most valuable within this environment. This evidence implies that the ‘good’ midwives are those who take on obstetric skills and are machine operators and do the ‘doing’, rather than the midwives who are watching and waiting, the one’s who are ‘being’.

To compound the problem nearly all of the midwives perceived that the women either relied on or valued technology in childbirth. Midwives perceive that women use technology to see what is happening inside their body and that this leads to connection between the woman and the baby. Midwives perceived an expectation from women that technology would be used when they enter the hospital environment. The midwife caring for Terri discusses this:

*“the women assume that there will be machines used in labour, it is their expectation. If it’s not in the room they will actually look around and say why isn’t there anything in this room, don’t you need to put a monitor on? Don’t you need to use a machine? It’s a reassurance for them isn’t it? They (women) like to see visually something; they like to see the readout of the heartbeat on the graph paper. But they are always asking if it’s normal if you hear baby move or something. So although it stresses them out they also find it reassuring. Its like they always want to see what’s going on inside”*  
(Transcript 41,p2).

The global theme overarches the organisational and global themes, which they all feed into, as shown in Figure 6.4. The global theme for the midwives’ themes is the focus of maternity care within the institution is medically led, technological and the normal birth process is not valued.

## **6.5 MATCHING THE ‘SITUATED KNOWLEDGES’ OF THE WOMEN AND THE MIDWIVES**

When analysing both the women’s and the midwives’ themes there were similarities found between the two. This chapter identifies these similarities and discusses them together. The similarities were that women do not understand physiological birth and doctors make the decisions and technology is valued.

The women’s and midwives’ themes are displayed next to each other in Figure 6.5, with the similarities displayed as the combined theme next to them. The global themes are presented at the bottom of the table. This part of the chapter will investigate these.

The uniqueness of this research is also displayed in this part of this chapter where matched cases of women and midwives are presented demonstrating the connection between the women’s and midwives’ ‘situated knowledges’. The women’s and midwives’ matched’ situated knowledges’ are displayed in appendix 4.

The thematic networks from the womens and the midwives match together to become combined themes, which are shown in Figure 6.6.



**Figure 6.5 Combined Themes**

<b>Women's Themes</b>	<b>Midwives' Themes</b>	<b>Combined Theme</b>
<p><b>Women Do Not Understand Normal Physiological Birth</b></p> <p>Midwife's role is processing. Concerned with 'doing': monitoring; measuring; reporting results to doctor.</p> <p>Providing pain relief is main role of a midwife<sup>52</sup>.</p> <p>Expectation to be rescued from the birth process from midwives and doctors.</p> <p>Unnecessary intervention.</p>	<p><b>Focus is on Midwives 'Doing' Rather Than 'Being'</b></p> <p>Expectation of women that midwives should be 'doing'.</p> <p>Women do not understand physiological birth.</p> <p>Two types of midwives.</p> <p>Models providing continuity of care not evident.</p> <p>No midwifery led environment.</p>	<p><b>Women do not understand physiological birth</b></p> <p>Women do not understand the process of physiological birth.</p> <p>Midwives identify that women do not understand the process of physiological birth.</p> <p>Midwives are 'doing', rather than 'being'.</p> <p>Women are not embodied.</p>
<p><b>Doctors make the decisions</b></p> <p>Doctor is the decision maker throughout childbirth experience</p> <p>Woman views midwife as handmaiden (midwife reports results to doctor to make the decisions)</p> <p>Doctor is necessary in childbirth</p> <p>Women feel safer in hospital (doctors' presence)</p>	<p><b>Medicalised culture constrains practice of midwives supporting normal physiological birth</b></p> <p>Doctors are 'free to roam'</p> <p>Midwife Co-ordinators influenced by medical decision making</p> <p>Guidelines support obstetric practices</p> <p>Midwives practice in fear of litigation</p> <p>Belief in normality is destroyed</p>	<p><b>Doctors make the decisions</b></p> <p>Women know doctors make the decisions</p> <p>Midwives know doctors make decisions, due to:</p> <ul style="list-style-type: none"> <li>-feeling disempowered</li> <li>-power differential between institution and profession</li> <li>-feminism</li> </ul>
<p><b>Technology is Needed/Necessary for Childbirth</b></p> <p>Technology is an important part of the midwife's role.</p> <p>Hospital is a safer than home to give birth.</p> <p>Expect environment to be technological.</p> <p>Influence of television programmes (show technological birth).</p>	<p><b>Technology is Needed/Necessary for Childbirth</b></p> <p>Value technology.</p> <p>Women value technology.</p> <p>Machines used as a replacement midwife/babyminder.</p>	<p><b>Technology is necessary in Childbirth</b></p> <p>Women value technology</p> <p>Midwives recognise that women value technology</p> <p>Midwives value technology</p>
<p><b>The focus of maternity care portrayed to the public is medically led, technological and the normal birth process is not valued.</b></p>	<p><b>The focus of maternity care within the institution is medically led, technological and the normal birth process is not valued.</b></p>	<p><b>The focus of maternity care is portrayed as being medically led, technological and does not value the normal birth process.</b></p>

<sup>52</sup> Wanting pharmacological pain relief appeared to link with wanting to be rescued from the normal physiological process, a symptom of not understanding the birth process. See section 6.3.1.

### **6.5.1 Women Do Not Understand Physiological Birth (women's themes)**

#### **Focus on Midwives 'Doing' Rather Than 'Being' (midwives' themes)**

These two themes titled above are essentially the same. The reason women expect midwives to be 'doing' rather than 'being' is because they do not understand the physiological process of birth. The women are not expecting them to be watching and waiting, as they would if they knew about the normal physiological process of birth, but expect them to be 'doing' something, usually in relation to technology or informing the doctor of results created from technology. Therefore, these two themes share common ground.

Feeding into this are the basic themes.

These are:

#### **Women do not understand physiological birth**

- Midwife's role is processing. Concerned with 'doing': monitoring; measuring; reporting results to doctor.
- Providing pain relief is a main role of a midwife.
- Expectation to be rescued from the birth process from midwives and doctors.
- Unnecessary intervention.

#### **Focus is on midwives 'doing' rather than 'being'**

- Expectation of women that midwives should be 'doing'.
- Women do not understand physiological birth.
- Two types of midwives.
- Models providing continuity of care not evident.
- No midwifery led environment.

Terri discusses how processing, monitoring, measuring and testing are the principal role of the midwife's job at 20 weeks of pregnancy and this view continues through to 6 weeks following the birth:

*Terri (20wks pregnant): "she (midwife) has filled in these notes and I have appointments at the hospital to see the consultant for scans.... She tests my wee and does my blood pressure"*  
(Transcript 1,p1).

*Terri (20wks pregnant): "her role (midwife) is about the tests and scans and things. She asked if I had any medical problems and stuff"*  
(Transcript 2,p2)

*Terri (6 wks following birth): "the midwife's job is to make sure everything is okay with me and baby by doing all the checks and things."  
(Transcript 4,p4)*

Terri views the role of the midwife to be 'doing', not 'being'; she does not understand the physiological process of birth and feels she will be reliant on pain relief during labour and birth. There appears to be an expectation that she would prefer not to go through the process of labour and birth, but that an operative option would be more favourable, therefore welcoming intervention. It also shows an underlying perception of expecting that she will be 'rescued' from not having to go through the process.

While discussing how she 'knows' about labour and birth through her interviews, Terri said:

*Terri (20wks pregnant): "I don't know much, I just know that I want as much pain relief as possible"  
(Transcript 1,p1).*

*Terri (36wks pregnant): "just that it's painful and I want to get it over with as soon as possible. I don't really think we should have to go through it, why can't we just have a zip instead and carry on like normal? Even if we knew when it would happen it would be so much better so we could plan things"  
(Transcript 2,p2).*

*Terri (6wks following the birth): "I didn't know much beforehand, not at all. But I didn't realise how painful it would be after having a section (caesarean), but it was nice to know when I was having him and my partner knew when it would be and stuff"  
(Transcript 4,p4).*

These views from Terri are now compared to the responses of the midwife caring for Terri:

*"there is a lack of understanding about birth, and it isn't just them (women) in labour a lot of it is TV (television), TV programmes. Even the reality TV programmes that show women in labour, they don't actually show how long it is they just show you snapshots of them. Things like the second stage women just think they are going to push for a two minutes and it's done really. They think it's going to be really easy and really quick because of what you are used to seeing.... If you have the people that have been to NCT classes they are a lot different, they tend to cope with it better because they understand the process of birth much better I find, they have had more education about it and they have paid to be informed, so therefore it is important to them to learn about it. Rather than just coming in and expecting us to do it for them they have actually gone out and want to help themselves, rather than naturally expecting us to do it for them. They tend to be much*

*better the ones who have been to those classes, so if you had the right education classes it would make a difference, it would help all of them"*  
(Transcript 41,p1).

The midwife recognises that women who search for and are interested in normal physiological birth will actively find information that they need, but women generally appear to be unaware or not interested in the process of physiological birth. The midwife caring for Terri identifies that women expect her to be 'doing', when she wants to be 'being':

*"I think women perceive our role as being there to reassure them and to offer them different levels of pain relief. I like just sitting in the room with them and do nothing. I just like to sit there and I don't think they expect that, they expect you to be doing something, they are always looking at me and you can tell they are thinking what are you going to do, you need to be doing something for me. (Terri's midwife has wide eyes) I can feel them saying to me are you going to do something to sort this out, rather than just go with it. I find it really difficult because you don't feel you can just sit there and talk to them because they are constantly thinking it. I've seen them look at me as if to say what are you going to do, are you going to do anything and I just think, no, you can't make me! It's awful (laughing). You feel uncomfortable because you feel like you should do something. The partners perceive it differently too; they always look at me as if to say what are you going to do, they always want you to constantly be doing something. They don't like to see their wives in pain, because they don't understand the process either. They just want you to sort the pain out, they don't understand that its normal and that its okay"*  
(Transcript 41,p1).

While discussing the culture within the labour ward environment the midwife caring for Terri, identifies that it is not only the practitioner's working within it that influence medicalisation, the women expect medicalised technocratic birth too:

*"It is hard standing up for normality. I've got myself into trouble and I've been made to feel really bad about it. They just do what they are told because otherwise you are outcast, you are seen as the black sheep because you are causing the trouble and you're the difficult and awkward one. It's just horrible. It's getting worse...Even the women are telling me to do something and intervene now. So I'm standing there in the middle, standing up for what I believe in and I have the co-ordinator from one side telling me I have to intervene for no reason and then I have the woman on the other side telling me to intervene too"*  
(Transcript 41,p2).

*"the mindset is now well there is the technology and there is the pain relief and there are doctors around to do caesareans, so why not just have it all,*

*have everything, she thinks why would I possibly want to go through birth without any of those things.*

*Its really, really sad. It just makes you think do I want to do it anymore? Why am I trying so hard to do it when no want wants me to practice as a midwife? They want me to practice as an obstetric nurse.*

*I'm not doing what I trained to do. I'm not doing what I came into midwifery to do. It's not midwifery. I've challenged it and all it has done has got me hurt in the process, like really hurt and let down by the system, because they don't stand up for you, they don't back you up. It's just horrible (pause).*

*(Terri's midwife has tears in her eyes and is visually upset)*

*I started out thinking I'm going to change it and I tried, but I got let down really badly; they didn't support me at all. Which was all to do with care of a woman that I was trying to keep normal and all of this rubbish happens. If I was put in the same situation again, I don't think I could put myself through that again. Before I was free, so if it means leaving the unit and go and work somewhere else I could. But, now with a child I can't I have to think about her too and I need a base, so I'm not going to stand up any more I'm just going to do what I'm told, because its more important that I stay where I am. I'm not going to put myself in that situation again, so I will have to comply.*

*Mary is the same she is constantly around here debriefing and she is on community so she has it less than me. She too is fed up of fighting to keep things normal and being seen as a troublemaker. It is easier to go along with the culture and do as we are told. She is sick of it too and she says she wouldn't have stood up and did what I did, even she would be too scared"*

*(Transcript 41,p3).*

*"The midwives in charge are going to be even more defensive and even more medicalised because they feel they are in control of all of the midwives on the shift and they have to cover their backs for everyone on the labour ward so that's why they behave that way. They are there to support us in our practice, but they don't they dictate practice to us. I've been asked to do ARMs (artificial rupture of membranes) on normally progressing women, why would I do that? So I challenge it with them and they say no I must do that even though I know it's not right.*

*The new normal birth guideline has caused so much trouble because it says women can progress at half a centimetre in an hour, they are so stuck in their ways they ignore it and say no its one centimetre an hour (laughing). I suppose it takes time for it to get through and for attitudes to change, but that is causing real debate"*

*(Transcript 41,p3).*

The midwife caring for Terri feels stuck in the middle between the woman and the midwife co-ordinator who are both supporting medicalised birth. She is trying to defend and promote the normal physiological process with opposing views from the woman and the midwife co-ordinator. Terri's midwife is forced into 'doing' when she wants to be 'being'.

Two of the midwives in this study like 'doing' (midwives caring for Mel and Issie). One of the midwives liked 'being' and 'doing' (midwife caring for Fions).

The remaining midwives liked 'being' but were forced into 'doing' (midwives caring for Terri, Danni, Sally, Jenny, Yvonne and Amy). All of the midwives identified that there were two types of midwives, those who enjoyed giving 'low risk' care and those who enjoyed giving 'high risk' care. Those who enjoyed giving 'low risk' care were identified as 'being' midwives and those who enjoyed giving 'high risk' care were identified as 'doing' midwives. The midwife caring for Fiona enjoyed both 'low' and 'high risk' care. The midwife caring for Terri discusses how there are two types of midwives:

*"They are easily identifiable. Even the newly qualified ones, you can see that they will go along with the co-ordinator in charge and whatever they are told to do and you can see the ones who are going to stick up for what they believe in what's right and what they have been taught and know that's how it should be"*

(Transcript 41,p1).

All of the women except for Sally expected the midwife to be 'doing'. Sally was the only woman who wanted the midwife to be 'being'. Interestingly Sally was the only woman who did understand and really wanted normal physiological childbirth:

*Sally (36wks pregnant): "I've been reading books. I've got the baby bible and the physiology of labour book, they have been essential reading. I found it really difficult to find out about the normal process of labour, but these discuss different techniques and how to cope. I have read all the ones you get with your bounty packs and Emma's diary I have read all of those. I have read about ten books. The books have definitely been good and I feel a bit more confident going into the birth"*

(Transcript 18,p2).

(Discussing how she expects the birth to be)

*"I want as natural a birth as possible. I would be really disappointed if I could not move around if I was all hooked up. If that happened it would probably be for my health or the baby's health. But, I am hoping to have a natural birth as possible I will not be monitored all of the time"*

(Transcript 18,p2).

(Discussing the birth),

*(following the birth): "The room was bigger than I expected it to be. There was just John and I. The midwife said whom she was and that she would be with us. She asked me what I wanted. I said I wanted to get through as much as possible on my own. She said that I was doing brilliant. She said do you want to try some gas and air? I didn't really like the gas and air very much, I found it quite restricting. She was really lovely; she dimmed the lights and kind of sat back.*

*We just got on with it together. Every now and again she would say try this? Then she said I was doing well and I would say, "I can't do it", she said*

*“you’re doing it mate just keep going. John said afterwards she just kind of sat around the corner. It was really lovely, I thought there might be doctors or more people around but it was lovely and intimate, it felt quite secluded and I was able to do my own thing. It was about two o’clock when I wanted to go to the bathroom. I wanted to be in the dark and I didn’t want to lie down”*  
(Transcript 19,p3).

The midwife caring for Sally wants to be ‘being’, which appears to have been successful with Sally. But very often she is forced into ‘doing’ due to the technocratic medicalised view of birth within this environment:

*“At the moment I feel able to stand up for what I believe in but I am not sure how long it will be before they grind me down totally... Some time ago I called for a second midwife, which again we never had to do; you never had that second person coming in interrupting and breaking that special relationship that you have formed.*

*The midwife stood miles away from me with her arms folded, the lady was standing up, her back against the doorway. I could not reach my equipment; I could not even reach my gloves. When I went out she said you can tell you’re “one of those” community midwives. It felt derogatory; it didn’t feel like any kind of compliment what so ever, it felt like she was having a dig at me for “allowing” the woman to stand up. Surely women can have babies how and where they want to have them? She just stood there with her arms folded, staring at me, I felt really humiliated.*

*You know, everything went beautifully the delivery of the baby was lovely, everything was fantastic.*

*Oh and we had all of that talk later from some of the midwives, that the doctors hate it when women don’t stay on the bed. Midwives pick up on that and so that’s becoming the culture, every woman has to be on the bed. It’s ridiculous. No one seems to trust the normal and the natural anymore, they only trust technology. Practice is now guided by fear and criticism, afraid of getting it wrong, afraid of litigation and somebody shouting.*

*I don’t think its supportive, not the trust, not the management. You just feel threatened all of the time”*

(Transcript 44,p1).

The midwife caring for Sally appears to be suffering punishment for not conforming to the ‘doing’, technocratic medicalised birth culture.

What is really interesting about Terri and Sally’s experience is that Terri was uninformed about the normal physiological process of childbirth and Sally was well informed. Their expectations of the birth were, therefore different. Terri expected to be rescued from the process and preferred to have the option of an operative birth, while Sally wanted a normal and as natural birth as possible.

Both of the midwives are ‘being’ midwives and forced to be ‘doing’ by the culture of the labour ward. What is really interesting is that because Terri

expected the midwife caring for her to be 'doing', due to her values and beliefs about childbirth, she received medical intervention and an operative birth. Sally was prepared for the normal physiological process and believed that she would have a normal birth and achieved this outcome. There appears to be a link here that shows that the woman's views about childbirth may influence the outcome. The midwife and woman working in the same paradigm together appears to make a difference.

All of the women, except for Sally, talked about their bodies like they were separated from them. The body is seen as a machine without a body and soul (Martin 2001).

*Denise (6wks following birth): "I also want to say that I felt like a piece of meat in that labour room, not a person. I felt degraded and disregarded. No one said to me, or my partner why they were going to use forceps. Two doctors just walked into the room, I didn't know who they were, they talked to the midwives, but not to me"*  
(Transcript 8,p4).

Not only are there signs of disembodiment here, the language used are similar to a rape victim. Kitzinger (1992) discusses these types of feelings conveyed by women in childbirth. I find these findings disturbing that women feel violated from their experience and this is embedded in their situated knowledges.

The midwife caring for Denise liked to be 'doing':

*"I like the drama I do. I like it when something goes wrong. I wouldn't choose to work in a midwifery led unit; I like someone who is eclamptic or something like that. I like the drama. There is nothing nicer than a low risk delivery, but I couldn't do that day in and day out. I like the drama really. We are all different and there are always going to be unwell ladies that need more intervention"*  
(Transcript 42,p1).

I am sure the midwife caring for Denise would have not realised Denise was feeling the way she did about her experience, but because the midwife enjoys her role in a 'doing' capacity and appears to welcome intervention. She may be perceiving the woman's body as a machine and disconnected from the woman's 'self'. This approach to Denise's care may have affected the outcome.

Within the thematic network this part will be identified as a combined organisational theme, 'women do not understand physiological birth' and



midwives identified in this study will be categorised as 'being', 'doing' or 'being and doing'. Most of the midwives are categorised as 'being', two as 'doing' and one as 'being and doing'.

This section identifies four points:

- Women do not understand physiological birth
- Midwives identify women do not understand physiological birth
- Midwives are 'doing', rather than 'being'
- Women are not embodied

### **6.5.2 Doctors Make the Decisions (women's themes)**

#### **Technocratic Medicalised Birth Culture Constrains Practice (midwives' themes)**

These two themes can be categorised together. This is because the medicalised technocratic birth culture on the labour ward constrains the practice of the midwives in supporting normal physiological birth. This culture exists because doctors make the decisions. Basic themes feed into both of these categories. These are:

##### **Doctors make the decisions**

- Doctor is the decision maker throughout childbirth experience.
- Woman views midwife as handmaiden (midwife reports results to doctor to make the decisions).
- Doctor is necessary in childbirth.
- Women feel safer in hospital (doctors' presence).

##### **Technocratic medicalised birth culture constrains practice of midwives**

- Doctors are 'free to roam'.
- Midwife Co-ordinators influenced by medical decision making.
- Guidelines support obstetric practices.
- Midwives practice in fear of litigation.
- Belief in normality is destroyed.

Jenny discusses the role of the doctor in relation to the role of the midwife:

*Jenny (20wks): the doctor tells the midwife what to do".*

*"Did you think you needed a doctor in childbirth?"*

*(Transcript 25, p1).*

*(following birth): " I needed a doctor to instruct the midwife to break my waters and he explained it in a bit more detail"*  
(Transcript 27,p3).

The midwife caring for Jenny believes that by not allowing doctors in the rooms of women experiencing normal labour she is protecting the women from the interference of the technocratic medicalised birth culture:

*"Midwives have a role in protecting normal childbirth and keeping doctors out of rooms with women who are midwifery led or progressing normally. Midwives should be at the door, saying you're not needed or welcome in here, but midwives lack autonomy now and relinquish all of their power to the doctor and see them as being the guardian of normal birth, rather than the midwife as the guardian which really shows how the status of midwives has eroded.*

*They don't stand up for what they know is right, so they are loosing credibility with the obstetric staff and they are quite happy to take normal childbirth as being theirs.*

*Normal childbirth belongs to the midwife"*  
(Transcript 47,p1).

Women's perception is that the doctor makes the decisions and that the midwife is the handmaiden carrying out his instructions. The 'being' midwife in comparison is trying to keep the normal birth philosophy alive, but even she recognises that she and the other midwives are expected to conform to the 'doing' philosophy of the 'medicalised technocratic birth machine' labour ward culture.

Jenny's 'situated knowledge's' convey her perception that doctors make the decisions:

*Jenny (20wks): " it is the consultant who decides everything, I will just do what the consultant thinks is right"*  
(Transcript 25,p1).

She had the opportunity to say that she decided what she wants in relation to her care, but she seems happy for the doctor to decide throughout her childbirth experience. She also thinks the doctor will make the right decisions for her, therefore viewing him as having the authoritative knowledge. The midwife caring for Jenny explains how women view doctors as having the authoritative knowledge, see the midwife as a handmaiden to the doctor and why the belief in normality is being destroyed:

*"I can't practice how I want to be perceived as a midwife, so I think they (women) get a skewed view of the role*

*I can't practice how I want to due to the constraints of medicalisation, because of midwives being expected to practice as obstetric nurses and I feel I am not supported as a normal philosophy is not supported. Lack of staff stops you offering water as an option for birth and staff shy away from offering it to women as they aren't given the time to get the skills to offer it.*

*A lot of the labour ward philosophy is based around medicalised guidelines, which restricts the practice of normality. Midwives on there see them not as guidelines but as rules that they have to abide by even though their clinical expertise and judgement tells them otherwise. Midwives won't practice outside the guidelines due to the blame culture and the fear. Frightened of being ostracised as there is no solidarity within midwifery and there is poor support by the managerial system with the whole medico legal aspect of midwifery now.*

*Going against the status quo is not worth the fight. Also if you become used to practicing within this medicalised culture then your view of normal becomes not normal and so you can't practice normally. If the culture had of been changed years ago then the obstetric nurses would have been seen as practicing abnormally, but now it's the real true midwives who are seen as acting abnormally. We need a cultural shift.*

*This has happened because lots of the veteran midwives, those with experience in normal childbirth have got disheartened and left the profession so those raw skills and that intuitive practice that comes with years of experience has gone and so can't be passed down to more junior students.*

*Midwives that are newly qualified are only seeing high risk stuff and are passing it down and when they become qualified they pass it down, so that's how the culture is changing. So medicalisation is being seen as normal birth now and anything outside that is seen as radical. So if a midwife now goes and gives a woman a bacon sandwich because it is what she wants and her contractions have gone off that is seen as abnormal and the midwife viewed as being a troublemaker.*

*This has led to midwives not working with their heart and what is right for the woman, but now working to what is expected of them"*

*(Transcript 47,p1).*

The perception of hospital being safer than home for birth is engrained within women's thoughts, as discussed earlier, nearly all of the women would not have a homebirth due to this reason, half of them identified the presence of doctors as making birth safe. They express how they are 'situated':

*Jenny (20wks pregnant): "I am having my baby in hospital, I wouldn't want to have it at home because it's safer in hospital, I would want all the doctors around me"*

*(Transcript 25, p1).*

*Terri (36wks pregnant): "I am having my baby in hospital, I wouldn't want it at home.... I would want to be where the doctors are in hospital, in case anything went wrong"*

(We went on to discuss this further as I was interested in this perception).

*I asked: "could anything go wrong in hospital?"*

*Terri: "probably, but not as much with doctors around"*

*I asked: "do doctors stop things going wrong then?"*

*Terri: "yes, I think they do"*

*I asked: "do midwives do you think?"*

*Terri: " I suppose so, but they aren't the ones in charge of you are they? The doctor is and they can do more to stop anything bad happening to you"*

*I asked: "so is the midwife's role how you thought it would be?"*

*Terri: "yes it is"*  
(Transcript 2,p2).

This part will now be identified as a combined organisational theme as 'Doctors make the decisions'.

Two main points are identified from this part:

- Women know doctors make decisions.
- Midwives say doctors make decisions, due to:
  - Feeling disempowered.
  - Power differential between institution and profession.Feminism.

### **6.5.3 Technology is Needed/ Necessary for Childbirth (Women's and Midwives Themes)**

This theme is shared with both the women and the midwives. Basic themes feeding into this are:

#### **Women**

- Technology is an important part of the midwife's role.
- Hospital is a safer than home to give birth.
- Expect environment to be technological.
- Influence of television programmes (show technological birth).

#### **Midwives**

- Value technology.
- Women value technology.
- Machines used as a replacement midwife/ baby minder.

Issie thought that the use of technology in childbirth was an advantage. She seems to not trust in her body to know she is carrying a baby. She seems reliant on a machine to inform her that the baby is there:

(Discussing how many times she has been for appointments at the hospital)

*Issie (20wks pregnant): "I've got a scan every three weeks really, it's good for me because that is the only way I get to see him and know that he is there. It's been really good"*

(Transcript 21,p1).

Midwives use machines as a replacement for themselves when they are not with the woman in the room. This may be due to not being able to provide one to one care or it may be part of the culture on the labour ward. Issie's midwife does not relate this experience to not being able to provide one to one care, but that it is accepted labour ward practice, part of the culture. Interestingly Issie's midwife is a 'doing' midwife, her response seems to show that she does not want to connect with the woman, that the CTG machine will do her job for her. This appears to indicate that she views herself as a technician, making sure that the 'machine' (woman) continues to work without any faults to delay progress in production. Issie is accepting of the machine being a replacement midwife, she does not seem to mind. This may be that she perceives her body to be a machine, as the response seems to show some disconnection from her body, that it is the technology that will tell her and the midwife when she has a contraction, she does not seem to trust in herself to know. She views her family as giving her the psychological and emotional support she needs and not the midwife.

(Discussing the birth),

*Issie (6wks following birth): "there was a midwife and two others to check to see if the baby was okay on the monitor, they were so good, they were lovely. She kept going out and coming in and going out and coming in. Then checking the heart monitor first and checking the pains on the monitor and asking me if I wanted more pain relief. She was really nice."*

*"When she went out the room were you frightened or anything like that? Wasn't frightened when she was out of the room, I was with my mum and my boyfriend, I felt fine and she was in every five minutes and I had the alarm if I needed her I only had to press it"*

(Transcript 24,p4).

*Midwife caring for Issie: "when we are using monitors in labour I give her the buzzer to use so she can get me if I leave the room. If she's got a partner with her to come out and tell us if she is unwell then that's fine and without*

going in the room you can go to outside the door and hear the ctg (cardiotocograph) machine so that you don't have to go in" (Transcript 46,p2).

*Yvonne (6 weeks following the birth): "I really liked having the scans, I liked seeing it on the screen. I could see her as a person; I could see she was moving. I liked that bit, which was good. I think they should give you a lot more scans through your pregnancy though. They only give you two standard scans don't they? I had a few more scans because they thought the baby was big. They only give you two generally; it's not enough, because anything could happen between the two scans. Anything could happen in that time".*

*I asked: "so is that the way you know something is wrong?"*

*Yvonne: "yes, its definitely not enough though"*  
(Transcript 36, p2).

*Yvonne: "I didn't want to be touched. They put the monitor on to start with, but it was okay so they took me off it. I didn't want to be touched...for the monitoring it was fine, it was being touched and things I didn't want. When I was on the monitor I asked if it was the normal rate and they said yes that's fine. I felt more in touch with her (the baby) and reassured that she was okay"*  
(Transcript 36, p4).

There is an acceptance that the invasion of the monitor is not actually invasive, but touch from someone else is. I find this a fascinating finding. The traditional midwife uses her eyes, ears and above all her hands to diagnose (Kitzinger 1997), but Yvonne's seems extremely fearful of the use of touch in labour. This may be because she wants to disconnect herself from her body. What is interesting is that she does not object to a machine touching her, in fact she wants more, not less contact with technology. Yvonne views more technology as safer for her baby's wellbeing, as well as it providing her connection with her baby. Yvonne engages with the material-semiotic, as a cyborg would, using the technology for her own perceived advantage.

(Discussing the use of the CTG machine)

*Midwife caring for Yvonne: "I think midwives like using machines. I would much rather not if I'm honest, but some definitely do like using it, particularly if you have two women in labour sometimes I've heard some of them say if you can put her on a monitor it will help look after her a little bit and if we are told that then that's what we have to do.*

*I don't like it. It involves too much writing. But some use it as a baby-minder. You could walk out of that room and that heart rate could just drop, it's happened to me when I've been called away to another room I've gone back in and there has been a big dip. That scares me to be honest.*

*You see people milling around sometimes and I'm thinking what's that CTG doing? Why are you not in the room? That's a difficulty sometimes"*  
(Transcript 49, p2).

In contrast the midwife caring for Yvonne likes 'being' as demonstrated here, but feels forced into 'doing'. This pressure appears to come from the women accumulated with the pressure of the culture within the labour ward environment. The midwife caring for Yvonne thinks women do value technology. This realisation will prevent her from trying to be a 'being' midwife and be a 'doing' midwife instead, as it is the wish of the woman and the technocratic medicalised birth culture she finds herself within.

*Midwife caring for Yvonne: " they (women) do find technology reassuring and want to know what the graph on the CTG machine means. They kind of really like it because it's the kind of society that we have.*

*We want to know when its going to happen and how long it is going to be and that kind of thing, but our job is unpredictable and I wish we could tell them that kind of thing and exactly how long it is going to be.*

*I think that women do tend to think the CTG machine is reassuring and they like it"*

(Transcript 49, p2).

This is an example of how the technocratic medicalised birth culture forbids the midwife caring for Yvonne to be 'being' and forces her into 'doing':

*"I don't like technology, but I can see why some people would find it useful if they are running from room to room.*

*I don't like the idea of someone not watching it in the room though. I like to be in my room with the woman, that's it. I've been told off for staying in rooms. I thought my job was to stay with the woman? The co-ordinator told me that I had to learn to multi-task. She said well we might need you out here and you don't need to be in there with that woman.*

*She had an epidural, syntocinon drip up and a CTG machine on and Intravenous (IV) antibiotics and I was quite newly qualified at the time. I was already getting into a state thinking I've got to keep an eye on the CTG, I've got to turn up the syntocinon, I've got to give iv antibiotics. I was getting myself in a pickle with that and then thinking I'm not supposed to be staying in here, so when am I supposed to be doing all this stuff and was repeatedly told that I needed to be outside the room. I said that if you need me you can find me in my room. It made me feel very sad. I will try my very best not to let it grind me down. On the whole I am quite well supported though. I just get on and do what I need to do. If they need me they can come and get me"*

(Transcript 49,p2).

The expectation of the environment on labour ward was surprising. The focus of the woman's expected experience is constructed around the concept of pain, butchery and technology.

*Yvonne (following birth): "the room wasn't as bad as I thought from things I had read. I expected there to be trolleys with knives on and things. It's in my pregnancy book. You associate knives with pain don't you? You expect everything being cut open and everything, not nice! It wasn't as bad as I expected it to be"*  
(Transcript 35,p3).

*Mel (36 wks pregnant): "In the labour room I expect there to be me and my husband, a bed and lots of machines I suppose and those silver trolleys with things on them, knives and scissors and things"*  
(Transcript 30,p2).

*Midwife caring for Terri:" I think the women view the labour rooms with a bed in the middle and a machine by the side of it. So then the first thing she does is goes on the bed and she expects you to wire her up to the monitor next to the bed and that's it, that's what she expects to be there for and that is what she expects of me. She expects to be put on the bed and monitored. The bed should be away against the wall so its not prominent in the room unless you are actually going to use it to do something"*  
(Transcript 41,p3).

Strategies within the institution are used throughout the organisation as a blanket policy, for example, a policy that fits nursing an ill patient are delegated from the top of the hierarchy down to the staff working on the factory floor. But, these may be of benefit to nursing but not to midwifery. Women are not ill; they are experiencing a normal physiological process. These strategies can work against this process.

*Midwife caring for Sally: "The productive ward, I believe the ethos is we don't actually have to go running off to plan what we need, so our time is more freed up.*

*It's brought in a culture of leaving all the pumps, the thermometers, sphygmomanometers and everything in the rooms.*

*They are not big rooms. But it is so we don't have to keep running to fetch them if we need them. The assumption is that we will need them.*

*I had an incident a couple of nights ago where I could not get the birthing ball to the entanox because of all the junk in the room, so I'm afraid it all had to come out rather angrily...that huge monitor stuck in the room must be terrifying, looks like a blooming darlek, I think it is frightening, sat up the corner. They are wondering what are you going to do to them? It looks like a torture chamber when it's all in there. What do you need really, you don't need any of it, so now it all comes out in my view"*

(Transcript 44,p2).

As discussed in Chapter 3, the mass media centres its information on technological birth. The evidence for this is found within this study, which shows the main influence as being from television programmes and celebrity stories



that promote technological operative birth as the option of choice for the rich and famous. When discussing what role the midwife did, Yvonne said:

*Yvonne (20wks pregnant): "before I was pregnant I saw what the midwife did just from magazines and television programmes really I suppose. You tend to get celebrities talking about pregnancy and labour and things now. They always look so glamorous afterwards don't they? I hope I'm like that. 'Posh' had her toenails painted when she had one of hers I think? Do you think they would do that for me? (Laughing)"*  
(Transcript 33,p1).

*Terri (20wks pregnant): "before I was pregnant I knew what the midwife did only from the family and telly, on the telly it's usually about when your in labour, it just looks technical and scary"*  
(Transcript 1,p1).

The midwife caring for Terri discusses the influence of television programmes on women's perceptions of childbirth earlier on in section 6.3.3.

Women perceive technology as experiencing a safer birth. Yvonne discusses how technology makes her feel that her baby will be safe if more technology is available in section 6.5.3. All of the women except for Sally felt that hospital birth was safer than a homebirth. To the women in this study technology appears to guarantee safety.

*Denise (36wks pregnant): "I am having my baby at the hospital, I knew that I wanted to have it at the hospital...I think with your first baby that if something went wrong you know, because I'm not sure what will happen because it's my first you know. I just feel a lot safer being in the hospital than I would at home".*

*I asked: "why does it feel safer?"*

*Denise: "because there is technology around me. If anything was to happen there are doctors there as well. I think it's just the whole thing, technology and doctors being there that makes me feel safer"*  
(Transcript 6,p2).

*Danni (following the birth): " I wouldn't have had my baby at home even if it was a straightforward birth I would rather be in hospital, because, if anything went wrong, in hospital there are people around like midwives, doctors and plenty of technology which you need around you when you have a baby, I have always felt like that"*  
(Transcript 11,p3).

Another interesting finding is that midwives that like 'doing' also perceive technology as providing safe births to women.

*Midwife caring for Fiona: "I like technology, its good for me definitely"*

I asked: "Do women put a bigger value on technology than midwives?"

Midwife caring for Fiona: "A woman always wants her baby safe"  
(Transcript 45, p3).

This part will be identified as a combined organisational theme: 'technology is necessary in childbirth'.

The evidence from this part identifies three points:

- Women value technology.
- Midwives recognise that women value technology.
- Midwives value technology.

## 6.6 CONCLUSION

The women's themes were generated from the women's interviews and their diaries. The midwives' themes were generated from the interviews with the women's supporting midwives. These basic themes fed into organising themes in the first part of this chapter. These were organised around the global themes for each, which are: *the focus of maternity care portrayed to the public (women) and within the institution (midwives) are medically led, technological and the normal birth process is not valued*. These were demonstrated in figure 6.3 and 6.4. The combined global theme is: *the focus of maternity care is medically led, technological and the birth process is not valued*, see figure 6.6. In the second part of the chapter I have matched, as far as possible, the woman and the midwife who were together at the birth, to provide a comparison view. This also allows for building a profile of the values and beliefs of the women and the midwives involved in their care, enabling commonalities and differences to be highlighted. This is detailed in a table in the appendix 4. Women and midwives themes were matched to find similarities, leading to combined themes. These have now been filtered into three main categories, these are:

### **Women do not understand physiological birth**

- Women do not understand the process of physiological birth.
- Midwives identify that women do not understand the process of physiological birth.
- Midwives are 'doing', rather than 'being'.
- Women are disembodied.

### **Doctors make the decisions**

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- Women know doctors make the decisions
- Midwives know doctors make decisions, due to:
  - Feeling disempowered.
  - Power differential between institution and profession.
  - Feminism.

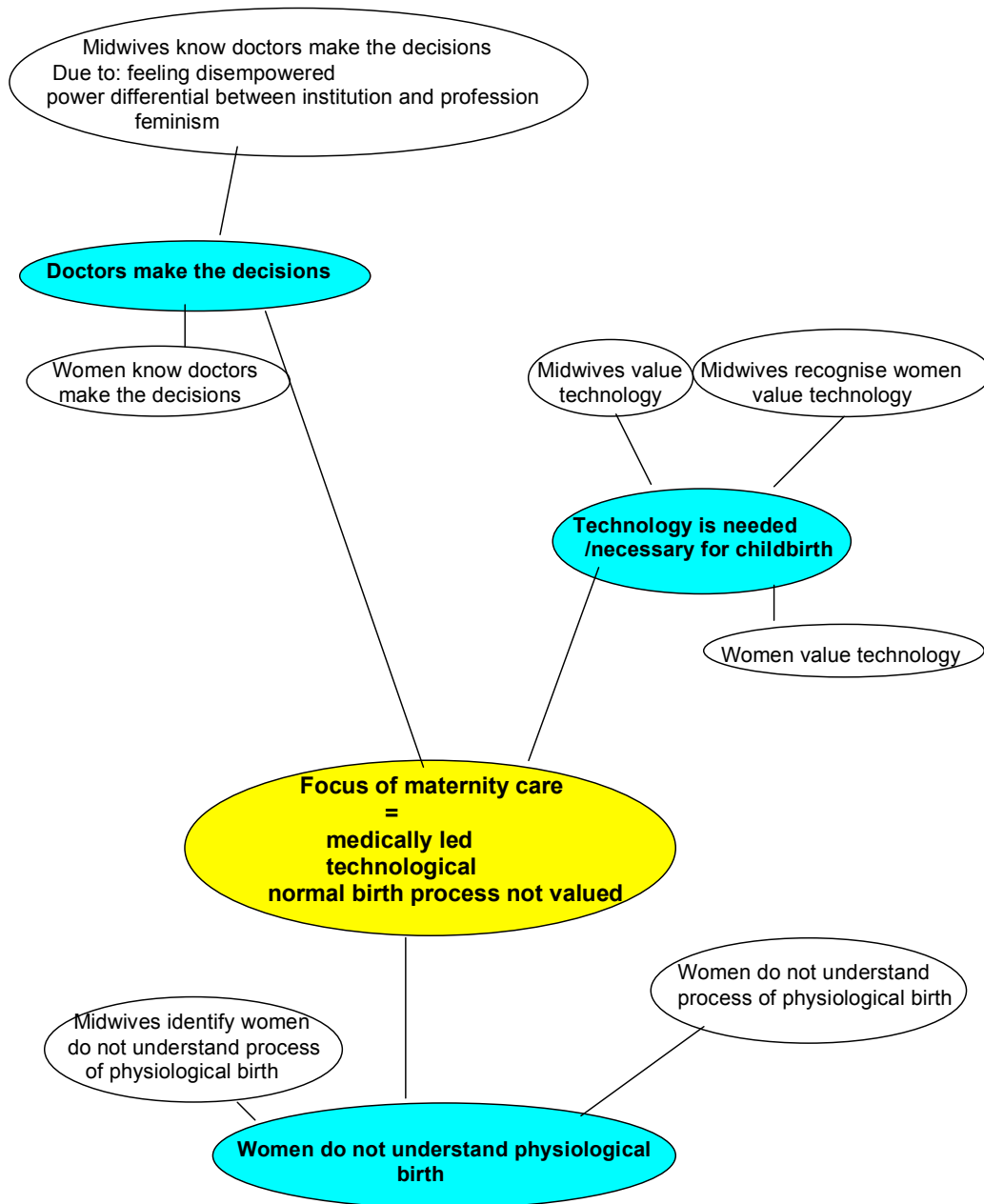
**Technology is necessary in childbirth**

- Women value technology.
- Midwives recognise that women value technology.
- Midwives value technology.

These categories are overarched by a global theme, which is: The focus of maternity care is portrayed as being medically led, technological and does not value the normal birth process.

The findings from this second phase of the research project will now be considered with the findings from the first phase. These will be discussed within the theoretical feminist technoscience concepts of Haraway (1997). Figure 6.7 shows how my research journey continues to build and develop.

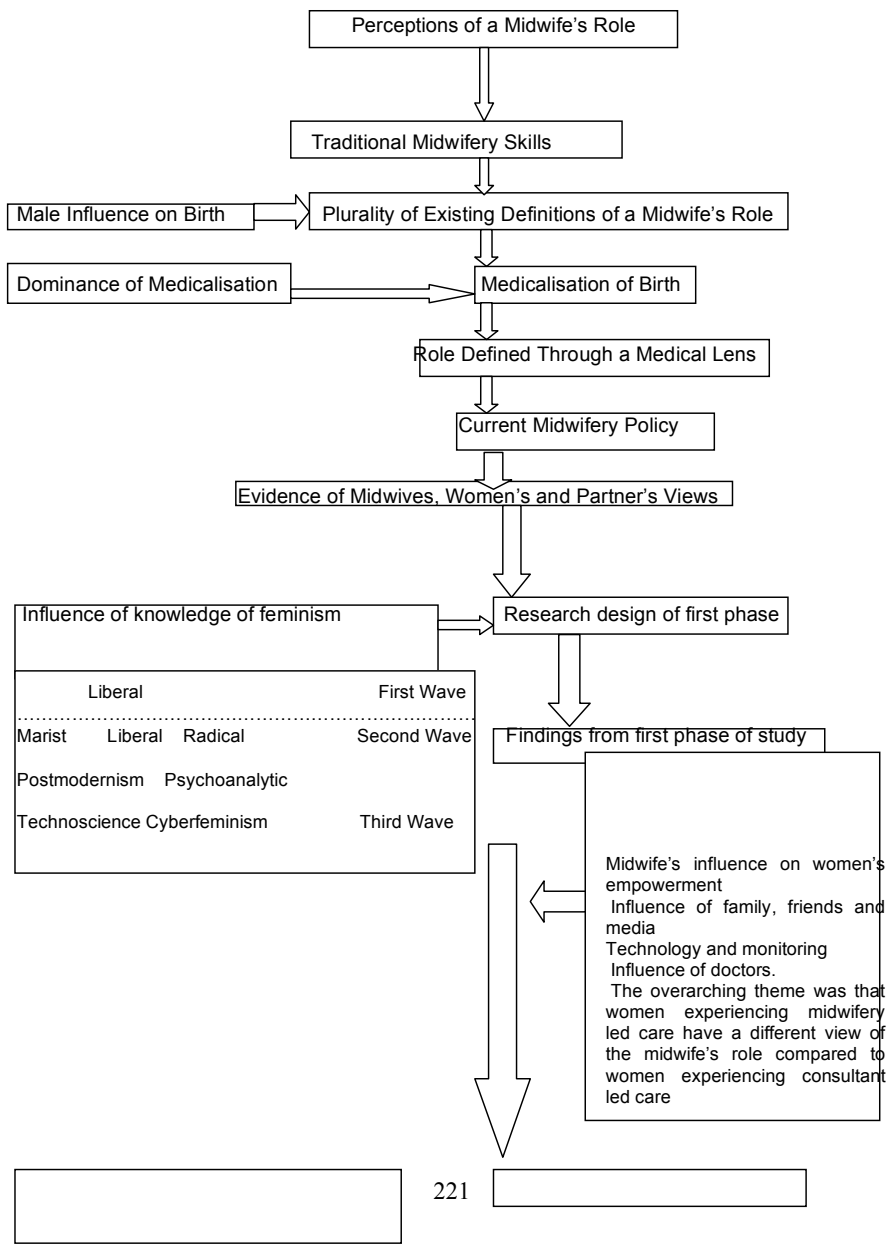
**Figure 6.6 Women's and Midwives: Combined Themes**



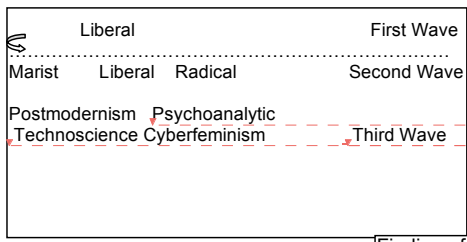
Midwives are 'doing' rather than 'being'

Women are not embodied

Figure 6.7 Research Journey



Identification of Haraway (1991, 1997) as Chosen theoretical perspective → Research design of second phase



Findings from second phase

- Women
- Technology is an important part of the midwife's role.
  - Hospital is a safer than home to give birth.
  - Expect environment to be technological.
  - Influence of television programmes (show technological birth).
- Midwives
- Value technology.
  - Women value technology.
  - Machines used as a replacement midwife/babyminder.

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## **CHAPTER 7**

### **DISCUSSION: A TECHNOSCIENCE PERSPECTIVE**

#### **7.1 INTRODUCTION**

The data found in the first and second phase of the study have been discussed in chapter 5 and 6. In this chapter the literature and Haraway's (1991, 1997) concepts will be used to explore accounts of women and midwives, to conceptualise the meanings of the findings.

This chapter is divided into sections, relating to the knowledge produced by this study. Due to the nature of the discussion, the themes on occasion fluidly cross each other. This study provides both original evidence and similarities to existing evidence. It relates the findings to Haraway's theories and summarises what we now know about perceptions of the midwife's role.

The overall aim, for both phases of this study was to explore the views of midwives and women, relating to the role of the midwife. The themes that have been identified in the first phase have been used as a basis to explore further the midwife's role in a consultant led setting. This has been achieved using a postmodern epistemological approach, drawing on feminist technoscience and focusing on the work of Haraway (1991, 1997).

The objectives were to:

- Explore how women receiving consultant led care view the role of the midwife through their pregnancy, birth and the post-natal period.
- Explore the themes identified in the first phase further in the second phase.
- Compare and contrast the perceptions of women and midwives in the second phase.

## **7.2 ORIGINAL KNOWLEDGE PROVIDED BY THIS STUDY**

In this section I discuss the original aspects of my research. There are five original findings.

### **7.2.1 Understanding Physiological Birth: Where Women are ‘Situated’**

Women experiencing consultant led care did not appear to understand the physiological process of birth, with the exception of Sally who experienced the empowerment influence found within the midwifery led women’s experiences described in section 7.2.2. This influence may possibly be linked to understanding physiological birth and how to get through the process themselves and take responsibility for doing it. This engagement with the physiological process appears to be at the root of the problem. Four of the findings in this study were: women expected to be rescued from the pain; the midwife was viewed as the ‘gatekeeper’ for pain relief drugs; midwives were perceived as ‘doing’ rather than ‘being’; and women felt that they were disembodied. These are all symptoms of women not understanding and/or engaging with the normal process of physiological birth. Arguably the women were conforming to the culture that surrounds their childbirth experience. Their ‘situated knowledges’ are a result of them adapting to achieve their goal through the network of semiotic material and syntactics that they find themselves within. Society, not just the hospital institution portrays the focus of maternity care as medically led, technological and the normal birth process is not sufficiently valued.

Women experiencing consultant led care view the midwife’s role as processing and concerned with ‘doing’, except for one of the women<sup>53</sup>. There appeared to be an expectation of the majority of the women that midwives and doctors should ‘rescue’ them from the normal physiological birth process. They also appeared to welcome and accept unnecessary intervention without question. Woven into this, is the expectation that providing pain relief is perceived as a

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<sup>53</sup> Sally was the exception. See chapter 6, section 6.3.1 and 6.5.1



main role of the midwife. The underlying cause that has led to the women experiencing consultant led care to situate themselves this way is that the majority did not appear have the understanding and belief in the normal physiological birth process. They were not situated the same as the women experiencing midwifery led care, with the exception of one, where the midwives gave the women an empowerment belief in the normal birth process. Midwives working within a consultant led environment and model of care perceived that there was an expectation of women that midwives should be 'doing' and that women did not really understand and believe in the normal physiological birth process.

The most significant original finding recognised that there are two types of midwives and identified them as those who are 'being' and those who are 'doing'.<sup>54</sup> Some of the 'doing' midwives did show elements of being nearer to 'being' when discussing some aspects of care, but still remained within the 'doing' end of the spectrum. The 'being' midwives did also move towards 'doing', but this was for reasons explained later in this section.

Lavender and Chapple (2002) suggested that there were two types of midwives, but were unable to delve any deeper. This study builds on this assertion, by categorising the two types of midwives and identifying their diffractions, values and beliefs<sup>55</sup>. McCrea (1998) discovered three types of midwives in relation to pain relief in labour. Although McCrea's (1998) study provides evidence that different types of midwives exist which this study supports, it is only attributable to one aspect of care in labour and not midwifery care in general<sup>56</sup>. The knowledge gained in this study is, therefore, original and has built on the foundations already laid by McCrea et al (1998) and Lavender and Chapple (2002).

The data from the second phase of this study relates to midwives who are identified as practicing within a consultant led environment and model of care. The midwives in the study who want to be 'being' are generally opposing the 'doing'. They feel forced into 'doing' while working within this environment and

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<sup>54</sup> Discussed in Chapter 6

<sup>55</sup> See chapter 6, section 6.4.1

<sup>56</sup> See chapter 2, figure 2.3.4.1

model of care, therefore adding weight that there are two types of midwives. An intriguing facet of the findings related to this is that these midwives are creatively weaving their 'being' into their practice while having to 'do'. This original aspect is probably the most exciting and important finding in this study. It is discussed in more detail, when engaging with Haraway's (1991, 1997) concepts in section 7.4. Other research related to this finding is discussed later on when investigating similarities to other research.

The need to be 'rescued' is also an important finding, as women and midwives identified that women want to be rescued by doctors and midwives from the normal physiological birth process. This is because the majority of the women experiencing consultant led care do not appear to understand and believe in the normal physiological birth process. The belief of committing the mind and body, as a whole entity, to 'deal with the process' is an important one; the empowerment belief described above is a valuable aspect of this study. It depends where women are situated as to whether or not they engage with the normal physiological birth process and want to know and understand it, the support and education they receive from midwives appears to make a difference. Some of the women appeared to be disappointed by not being 'rescued' and expressed their desire for a medicalised technological birth. Symon et al (2007) found that when women rated their own birth, in terms of risk factors, the women who had experienced a midwifery led model of care and environment expressed improved outcomes compared to those who had experienced consultant led care. Symon et al's (2007) study shows differences in women's perceptions of their experiences between the two models of care. This study builds on this evidence and is original in terms of reflecting both women and midwives perceptions of their experiences of models of care and by providing more depth into both groups viewpoints.

### **7.2.2 Midwives Influence on Women's Empowerment: A Key to Engagement**

Midwives influenced women's empowerment of the normal physiological birth process in a midwifery led model/ birth setting, which was found in the first phase of this research study. One of the women in the second phase also exhibited this. She also understood and wanted to engage with the normal

physiological birth process, therefore showing some fluid overlapping of models of care. The influence on women's empowerment appears to be key in engaging women with the normal birth process. The distinction between this occurring in a midwifery led model, with only slight overlapping occurring with women experiencing a consultant led model has not been found within any other study. Robertson (1994) argues that the all consuming and overwhelming nature of birth, including the weathering of pain is an empowering process for women and a process that should not be withheld unless it is detrimental to her or her baby's wellbeing. The findings suggest that it is the midwife that has given them the belief in the normal physiological process of birth and empowered them to 'get through' this process. The midwife helped them believe in an embodied process of mind, body and soul. The underlying framework of the midwifery model is the understanding and the value of connection, the understanding of relatedness of the body and mind (Foster et al 2004). This connection and understanding was apparent in the findings. Anderson (2006) argues that trust can give feelings of safety and relaxation. She discusses the theory of the relationship between trust and oxytocin levels in the body, if trust is there oxytocin levels will increase, which in turn will progress labour, reduce blood pressure, increase blood circulation and increase healing of wounds. Therefore, the underlying principle of empowerment may be 'trust'. Empowerment may also contribute to significant health benefits for mothers and babies. The midwives who created the belief in empowerment to these women worked mainly within a midwifery-led system, where autonomous practice would exist. Kitzinger (2005) discusses how wherever autonomous midwifery exists perinatal mortality rates are at their lowest.

There is existing theory in business organisations and nursing related to influences of empowerment. Kanter's (1977) theory of empowerment has been tested within organisational settings in nursing (Laschinger et al 2001, 2004; Manojlovich 2007; Faulkner and Laschinger 2008), resulting in empowering work structures, which promote optimal nursing practice.

Laschinger et al (2010) proposed a model that links working conditions of nurses to nursing care processes and patient outcomes, based on Kanter's

(1977) model. They argue that access can be gained to patient empowerment, through nurse psychological empowerment. In the nurse and patient situation, within this model, nurses share power with their patients. Laschinger et al (2010) argue that as a result of having greater structural and psychological empowerment in their work settings, nurses are more likely to employ patient empowering behaviours, which will then in turn, result in increased levels of patient empowerment.

This type of patient empowerment is different as it works on an illness, getting better model, rather than the nature of a wellbeing model. Generally women experiencing childbirth are well and not ill, just experiencing a normal physiological process<sup>57</sup>. Some of the principles within Laschinger et al's (2010) work can be related to midwives working in models or environments that foster the same type of structural empowerment, as the one seen with the midwifery led women in the first phase of the research. This translation into midwifery has not been conceptualised before. Structural and psychological empowerment influences can be related to the influence the midwives had on the women's feelings of empowerment on the normal physiological birth process. In figure 7.1 I show how Laschinger et al's (2010) model can be related to this study.

These factors may be able to flourish in a midwifery led setting more easily, due to the authoritative knowledge being based on the normal physiological process, even though it would be beneficial for this to be accessed by all women in all models and birth environments.

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<sup>57</sup> Downe and Mc Court (2004) discuss this in more detail and have identified a model of 'salutogenesis' to be used within maternity care. Discussed further in section 7.7.

**Figure 7.1 Relating Laschinger et al's (2010) model to midwifery practice**

Component of Laschinger et al's model.	Example of midwife empowering behaviours
Access to Information	Fluidity of information between midwife and woman. Easy access to midwife and midwifery led unit. For consideration- Continuity Creative use of information technology
Access to Resources	Women given one to one information about normal physiological process by community midwife and reinforcement at each contact. Midwives encouraged them to believe they could cope with physiological process without intervention or drugs. Women knew and believed in physiological birth process and what they needed to do.
Access to support	Phone contact. Regular contact.
Access to opportunities to learn and grow	One to one coaching. Active birth sessions.
Informal Power	Alliances with family and friends. View the woman as partner of process.
Formal Power	Adopt flexible approach. Promote self-determination. Birth coaching.

### **7.2.3 Technology: A Necessary Tool for Childbirth**

This study found that women experiencing consultant led care value technology. The midwives working within a consultant led model of care also recognised that women valued technology. Some of the midwives valued technology, the majority recognised other midwives who did. No other study has recognised these three aspects together within a consultant led model of care and environment, which contribute to the perceptions of the role of the midwife, therefore this finding within the study constitute original knowledge. Crozier et al (2007) identified the value midwives placed on the use of technology, but this study builds on this knowledge by reflecting this with women's thoughts on technology in relation to the role of the midwife and its role within childbirth. Houghton et al (2008) found that women viewed using technology was an important part of their role. This study also builds on this knowledge, but has the added advantage of comparing this to the views of the midwife about each of the women's experience of birth. The findings appear to be the result of the technocratic medicalised birth culture women and midwives are embroiled in, through the medium of a consultant led model of care and birth environment. Society reinforces this birth culture via media interpretations of birth delivered through a technocratic medicalised perception. The value placed on technology in childbirth is discussed within similarities to other knowledge.

### **7.2.4 The Lie of The Land: Doctors Are The Decision Makers Within the Technocratic Medicalised Birth Culture**

This study shows that women receiving consultant led care perceive that doctors make all the decisions. The study found that midwives frequently relinquish their autonomy to doctors because of the culture they are working in. This may be due to the power differentials, of the values placed on conflicting ideologies between the institution they are working within and the midwifery profession and its values. The underlying reason that doctors make the decisions is due to power differentials found between the professions and as the doctors have power positions within the majority of NHS institutions; this

differential appears to be seen as the norm. Midwives know 'how it is', so become supportive of this situation and refer to the doctor for all decision-making, even if it concerns normal childbirth. This is reflected through the hierarchy of the institution and runs through as a two-way connection within society, which relates back to gender issues being a key sociological aspect within the world. This is why feminism is at the heart of understanding this aspect. This pertains to the global theme: the focus of maternity care is portrayed as being medically led, technological and does not value the normal birth process.

Women experiencing consultant led care felt safer in the presence of doctors and technology and perceive doctors as being necessary in childbirth. Houghton et al (2008) found that women feel hospital is a safer environment to give birth and perceived that the use of technology was an important part of the midwife's role, which supports this finding. This view was identified within the whole population in Houghton et al's (2008) study, not necessarily relating to women experiencing consultant led care only. Women observed the midwife report test and machine results to the doctor and therefore situated the midwife as a 'handmaiden' to the doctor. They perceived the doctor to be the decision maker throughout their childbirth experience. These perceptions are present because underlying these, within this consultant led environment and model of care, the doctors appear to make the decisions. Women perceived doctors and technology as making birth safe, this is original knowledge, but it also corresponds with other research, discussed below in section 7.3.

#### **7.2.5 The Focus of Maternity Care in Society is Medically Led, Technological and the Normal Birth Process is Not Valued**

The women who experienced a consultant led model of care/ birth setting and the midwives working within this model of care/ birth setting are functioning within the global theme<sup>58</sup> that identified: the focus of maternity care as being medically led, technological and the normal birth process is not valued.

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<sup>58</sup> Described in chapter 6, in the combined women and midwives themes section 6.5

### **7.3 SIMILARITIES TO EXISTING KNOWLEDGE**

Having outlined the originality of this study I will now discuss the similarities between my findings and what is already known.

#### **7.3.1 The Technocratic Medicalised Birth Culture: It's Relationship With How Midwives Practice**

This study provides original findings by identifying that there are two types of midwives: 'being' and 'doing', as discussed in section 7.2.1. The midwives expressed that the technical skills of using machines and obstetric values and practices are viewed as the most valuable within this environment. This evidence implies that the 'good' midwives are those who take on obstetric skills and are machine operators and do the 'doing', rather than the midwives who are watching and waiting, the ones who are 'being'. This is similar to Hunter's (2005a) findings where midwives working in community based teams were identified as working in a 'with women' model practiced in an individualised holistic view and met individual women's needs, which is homogenous to the 'being' midwives' philosophy in this study. Those working within the hospital worked with an institutional approach to birth, described as 'with institution' midwives, which corresponds with the 'doing' midwives in this study, although some of the 'doing' midwives did move towards some elements of 'being', but remained at the 'doing' end of the continuum. When McFarlane and Downe (1999) assessed midwives training needs they too found two completely different concepts of midwifery depending on the environment they were located in community or hospital, which correlates with Hunter's (2005a) study<sup>59</sup>. It also resonates with this study, but related to the midwives' preference to be 'doing' or 'being' and their related values. My study takes a step further by identifying that there are two types of midwives, which flow within the technocratic medicalised birth culture. The 'doing' midwives are able to work easily within this environment, while the 'being' midwives have to adapt their

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<sup>59</sup> See chapter 2, section 2.



skills to fluidly move across to 'do'. This finding is distinctly original knowledge discovered in this research<sup>60</sup>. Davis-Floyd (1994) provides some explanation for this. She describes how the technocratic model of birth results from first deconstructing the natural process of birth and then dissecting it into components which can be measured, manipulated and reconstructed through the use of various technologies. This allows 'control' of the birth process. As this involves technologies and measuring of the components the 'doing' activities are viewed as essential. Women and midwives experiencing consultant led care are manipulated by the technocratic birth culture into seeing that this is 'how birth is'. This finding also gives rise to another question; how would 'doing' midwives function within a midwifery led environment? Would they fluidly adapt to 'being'?

The 'being' concept of this study can also be related to 'nesting' and 'matrescent' care, as described by Walsh (2006). He challenges maternity services to consider the importance of this. From his findings from care in a Birth Centre he found that:

*"When exposed to a place and space for childbirth, not hedged around with the paraphernalia of biomedicine, women connected to an alternative understanding of safety, where social, psychological and cultural meanings complemented and appeared to sometimes supplant, conventional mortality and morbidity concerns."*

(Walsh 2006:238)

There are clear accounts in my study of the compromise made by many of the midwives to be 'doing' when they want to be 'being' due to the technocratic medicalised birth culture of the consultant led model and environment. An example is shown within chapter 6 where Terri's midwife is forced into 'doing' when she wants to be 'being', which can also be viewed as adaptation, as described in section 7.2.2. Walsh (2007) describes how within a midwifery led environment the process of normal physiological birth is supported by the midwives working within it and because the women who choose a Birth Centre to birth there, they too will be informed of and committed to working with the normal physiological process of childbirth. Walsh (2007) describes how

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<sup>60</sup> See section 7.2.1.

investment in social capital among the staff results in supporting each other in their social and family capacity, viewing each member of the team as a whole person, which also reflects in their care of the women. This is opposite to the mechanistic productivity model of the consultant led labour ward. The midwives are working within this technocratic medicalised birth culture and must conform to be accepted, this ensures they keep their employed status within the institution. Anderson's (2002) description of how cats in a laboratory can be compared to women in labour reflects these findings. She describes how the cats are taken in labour from their darkened room to a brightly lit, noisy, modern laboratory where they are attached to monitors and probes, while subjected to scrutiny by strange technicians, who constantly come in and out with clipboards. The technicians conclude that the cats do not labour very well, which leads to intervention from machines to improve their labours and monitor their kitten's oxygen levels, pain killing drugs, tranquilisers and drugs to make labour become regular and stop it from slowing down.

Some of the midwives interpreted that women expected midwives to be 'doing' something to them, perceiving that women were unaware of the value in observing, waiting and watching skills. Walsh (2007) recognised that midwives in a birth centre environment are allowed to perform 'being', to be in the room 'with the woman' rather than having to 'do' something. 'Being' is essentially spiritual. Pembroke et al (2008) describes this as how the midwife considers the concepts of responsibility and availability; she opens herself up to the woman in a sensitive, supportive engagement. Buber (1947) defines responsibility as being able to respond to the claims others make on us. This is achieved by using awareness of 'observing' and 'looking on'. He describes this as an artistic perspective, involving trusting one's intuitive powers. Marcel (1964) discusses how receptivity in midwifery care involves the midwife playing the role of a host. All of these encompass the perception of 'being'. Walsh (2006) found that the Birth Centre environment elicited nesting-like behaviours from both women and the staff. This was central to a type of nurturing orientation that was conceptualised as 'matrescent' (becoming mother) care. He describes matrescence as relationally mediated, not grounded in clinical skills, which could be applied to the 'being' midwives in this study. In Anderson's (1997) study relating to coping with pain in labour she found women who laboured

without opiates or epidural anaesthesia were able to enter an altered state of consciousness involving separation of mind and body. This was facilitated by an endorphin release; this allowed their minds to 'let go' and their body to be in control. The midwife was found to be crucial in this process by being competent, trusted and familiar, quiet and calm, supportive and unobtrusive and by providing a 'safe anchor' for the woman to enter this state. All of these encompass what I determine as the meaning of 'being'.

The findings suggest women and midwives encompassed in a consultant led model of care are working within a 'pain relieving' approach, where pain relief is interpreted as a major function of a midwife, suggesting that it is the woman's choice to work within this paradigm. The women who experienced consultant led care in the study, generally viewed the midwife as the 'gatekeeper' to pain relieving drugs and view this as part of her 'doing' role. She is perceived as 'doing' something to relieve the pain; taking it away so that the physiological process does not have to be dealt with. It is another form of 'rescuing' women from the physiological process of birth. Leap and Anderson (2005) describe midwives who freely offer pain relief to women in normal labour as ultimately viewed as both agents and products of patriarchal oppression, fostering the notion of the woman as weak, unable to cope and dependant.

Walsh (2007) discusses how informed choice is an ethical imperative, which influences practitioners' responses to maternal requests for pain relief in labour. In Leap's (1997) study on pain relief in labour she found that in training hospitals where the majority of women have epidurals many students were rarely experiencing seeing women having drug free labours and so a pain relief paradigm is perpetuated. Leap and Anderson (2008) contrast two paradigms, a 'pain relief' approach and a 'working with pain' approach. Leap and Anderson (2005) acknowledge that women in western countries expect pain relief, but call out to women and midwives to work 'with the pain'. Lundgren et al (1998) recognise that to offer women in normal labour pain relief is to deny them their transformation and their triumph of giving birth in a physiological context. Walsh (2009) indicates that inadequate service provision and an impoverished approach to labour pain rather than women's preferences are contributing to the rise in epidurals.

The 'being' midwives want to work in a 'working with pain' paradigm, but the majority of the women experiencing a consultant led model of care and birth environment expect to have a 'pain relief' approach provided. The midwife is compromised into giving the pain relief, through pressure from the women and also from service demands, as the midwives are unable to stay with her to 'work with the pain', due to not being able to give one to one care. The beliefs and actions of the practitioners working within this model of care and birth environment are compromised to practice in a certain way and this may have led to this preference for women. This may have occurred through their observations of midwives or through the media.

Within the consultant led environment and model, midwives perceived doctors as 'free to roam' anywhere, that all of it is their territory, even though some birth rooms had been identified as midwifery led. Midwife co-ordinators were perceived as influencing technocratic and medicalised decision-making. Midwives viewed guidelines as supporting obstetric practices and felt midwives generally practiced in fear of litigation. Within this culture midwives viewed their belief in normality to be destroyed. These factors are all due to the medicalised culture constraining practice of midwives supporting normal physiological birth.

### **7.3.2 Authoritative knowledge**

Authoritative knowledge was evident in the findings. This study shows women and midwives assume that doctors make the decisions within a consultant led model of care. Midwives as well as the women demonstrated in this study that the doctor has the authoritative knowledge. This can be threaded through the actions of the 'doing' co-ordinators in the consultant led environment. The 'doing' co-ordinator is perceived by the midwives in the study as acting as a modest witness of the technocratic medicalised birth machine on behalf of the doctor.

In an example shown in chapter 5, the midwife is in a consultation room with the woman and the doctor. As well as the woman, the midwife is also viewing the doctor's knowledge as authoritative, as she does not request the doctor to explain himself to the woman if she failed to understand, she waits until the

doctor has gone before explaining to the woman. Jordan (1997) discusses how knowledge is communicated downward along a hierarchical structure of which the woman is the most distant member. All major decisions are reserved to the doctor, who is in charge of 'the facts', the knowledge on which rational decision-making is based. The doctor is a 'modest witness' of the technocratic birth machine, a modest witness of 'truth based on no truth'.<sup>61</sup> The findings indicate that authoritative knowledge within this power context exists. Three women, following the birth, felt that they had no control of what was happening in labour and birth. Authoritative knowledge is displayed in all three examples. The women accepted the authoritative knowledge as being from the doctors and her knowledge as the least significant. They also showed disembodiment<sup>62</sup>.

### **7.3.3 Media Interpretations of Childbirth: Influences on Perceptions of the Midwife's Role**

This study adds further evidence of how women perceive risks, pain and technology. It demonstrates how the media appears to influence women's views about childbirth and the role of the midwife.

Television programmes had a considerable influence on not only how women viewed childbirth, but also how they perceived the role of the midwife in this study. The majority of the women at 20 weeks and 36 weeks of pregnancy viewed television as influencing their perception. Celebrity stories of childbirth also had an impact on this<sup>63</sup>. Television programmes generally portray childbirth as technological and complicated, which was reflected in the women experiencing consultant led care's situated knowledges. The findings show how cultural imagery has influenced women in relation to childbirth and the role of the midwife. The technocratic medicalised birth machine is promoted through the medium of the media by the 'modest witnesses' prophesising this culture.

Existing research concerned with the influence of women's perceptions of childbirth includes contributions from Kingdon (2009), Kitzinger (2005), Martin (2001) and Betterton (1996). Beech (2000) and Clement (1997) discuss how

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<sup>61</sup> See chapter 7, section 7.4.1

<sup>62</sup> See chapter 6, section 6.3,

<sup>63</sup> See chapter 4, section 4.3, which contains the current evidence in relation to childbirth imagery.

the power of television in particular shapes the view of contemporary British women concerning the risks, pain and inconveniences associated with childbirth.

#### **7.3.4 Valuing the Normal Physiological Birth Process**

The normal birth process being valued is found to be an important factor for the process to be able to function freely and successfully in this study. Nearly all of the midwives felt that they needed to be able to work in an environment conducive to normal birth and expressed wanting to work in a midwifery led environment to give them greater job satisfaction. Two of the midwives did not interpret working within a model providing continuity to women as beneficial. Issie's midwife expressed how providing continuity can provide disadvantages for them, as they would have to continually give care to women they have found to be difficult to care for. Many of them felt continuity with women would help them to develop a better relationship with women and their birth partner. Davis-Floyd et al (2009) and Sandall et al (2009) discuss how the value of midwifery led environments and models of care can influence improved outcomes for women and lead to greater job satisfaction for midwives. Walsh (2007) shows the incredible value of birth centres in protecting normal birth physiology.

Midwives' views of how they are influenced by the technocratic medicalised birth culture on the labour ward is a further contribution to Davis Floyd et al's (2009) concept of 'birth models that don't work', which is found within this study. Labour wards across the U.K. continue to be influenced by active management of labour (O'Driscoll and Meager 1980), which is discussed in more detail in Chapter 2. This type of management views women as mechanistic, the labour ward runs as an industrialised model, similar to Fordism (Giddens 2001), also discussed in Chapter 2. The assembly line must keep on running and no delays are acceptable. The result of this philosophy is that within the consultant led environment and model of care the focus is on midwives 'doing' rather than 'being'.

The findings disclose that midwives who have previously worked within a midwifery led environment found conflict with the ideologies of the technocratic medicalised birth culture in the consultant led birth environment. The midwives

felt that this does have an impact on junior midwives working within this environment and felt that they are more likely to comply with the demands of the technocratic medicalised birth machine, dictated by the doctors and 'doing' midwife co-ordinators. This resonates with Hunter's (2005b) study where she found that senior midwives attempted to maintain their position through unwritten rules and sanctions<sup>64</sup>, supported by their claim to greater clinical expertise and experience. Junior midwives rarely challenged this authority; their responses were often subversive and designed to create an appearance of compliance. Over half of 164 student midwives in a survey across the U.K. revealed that they had suffered bullying behaviour by midwives (Gillen et al 2009).

### **7.3.5 The Value of Technology**

The majority of the midwives in the study interpreted that the women either relied on or valued technology in childbirth. Midwives perceived that women use technology to see what is happening inside their body and that this leads to connection between the woman and the baby. Midwives evaluate that there is an expectation by women of technology being used when they enter the hospital environment. Women experiencing consultant led care perceived technology as an important part of the midwife's role. This shows that the overriding factor here is that women perceive that technology is needed and necessary in childbirth. The midwives working in this culture perceived that women valued technology. They also recognised that midwives valued technology, not always themselves, but had witnessed this value displayed by other midwives, including midwives using machines as a baby minder or as a replacement midwife. Underlying these is the fact that technology is needed and necessary for childbirth within this culture.

This study is supported by Houghton et al's (2008) research, where they found that women perceive the use of technology to be an important part of the midwife's role, when they investigated choice of place of birth. The findings of this study resonate with Davis-Floyd's (1994) findings that women value the medicalisation of birth, which includes technology as a tool used for obstetric control. Martin (2001) described how women in technological medicalised

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<sup>64</sup> See chapter 4, section 4.5 in relation to 'modest witness'.

environments do not see themselves as a whole person. All of the women, except for Sally, talked about their bodies like they were separated from them. The body is seen as a machine without a body and soul (Martin 2001). Medical science has contributed to the fragmentation of the unity of a person.

*“Science treats the person as a machine and assumes the body can be fixed through manipulation. It encourages us to ignore, other aspects of ourselves, such as emotions or our relations with other people.”*

(Frank 1931:1053)

Davis- Floyd (1998) argues that through using technologies we are ‘cyborgifying’ babies throughout pregnancy and birth; no one considers the high pitched noise in their ears from the ultrasound waves, how the insertion and location of the amniocentesis needle feels, the trauma of having an electrode screwed into their heads and the loss of the cushion when the membranes are ruptured with the fierce contractions. The women experiencing consultant led care in this study did not consider the trauma of technologies to their babies.

Sinclair (1999) identified that technology did not undermine the midwife’s position, but instead appeared to focus and strengthen it. Experiences of women who received consultant led care, which resonates with this finding of Sinclair’s (1999). The ‘doing’ midwives did view technology as focusing and strengthening their role but the majority of midwives who were ‘being’ midwives did not view technology as focusing and strengthening their role. They viewed it as undermining and threatening their role, but they still integrated with it when they conversed with ‘doing’ practices to comply with the culture. Sinclair (1999) also found that women and their partners viewed the CTG machine as an electronic window, which offered them evidence of the wellbeing of their baby, the machinery appeared to aid them in the process of giving birth. I did find that women had an expectation to be rescued from the birth process by doctors and midwives and they did expect to be attached to a machine, therefore, the technology may have aided them in the process of birth. Interestingly, Sinclair (2003) discussed drawings from women that she had asked them to do following the birth of their babies. These were all different, but many of them portrayed machines and technology in the room, with lots of people in attendance. The other interesting factor was the presence of knives and



scissors in the drawings. This corresponds with the findings of this study relating to what the women expected there to be in the birthing rooms, they described machines, scissors and knives too.

Sinclair (2009) revisits her 1999 study and moves into the realms of thinking that there are two types of midwives, she states:

*“Ten years later, the battle continues and entrenchment has become part of the fabric of practice, with some holding fast to man-managed labour in a consultant-led environment or woman-led labour in a midwife-led unit”*  
(Sinclair 2009:29)

Sinclair (2009) appears to suggest that a woman-led approach should be possible in a consultant-led environment. Interestingly Crozier et al (2007) found that midwives practicing in two different units practiced differently. One unit relying on traditional midwifery skills more than technological skills and machinery, whilst the other relied more on technological skills and machines for their practice. This suggests that it depends on the values within the environment midwives are working within to how they practice in the way that they do.

This study shows the difficulty of integrating ‘being’ values of the natural and normal into a culture that supports the technocratic medicalised birth culture, as these values appear worthless. Therefore, ‘being’ midwives are integrating with technology to ‘do’ because they have to, not because they want to. Midwives identified that they are unable to provide one to one care on occasions and will use technology to replace them. Most of the midwives felt that machines were used as a ‘babyminder’ or to replace a midwife. Reliance on technology is viewed as acceptable within this discourse. The rise of faith within science and technology has led women, midwives and doctors to trusting the machines rather than the woman’s reported experience of their own observations (Beech and Phipps 2004). This has led to widespread routine application of obstetrical technology at hospital births. The route to this problem lies in the hierarchical position of the doctor over the midwife, which is based on his control of obstetrical technology and the dominance of the obstetric model over the midwifery model, which remains the basis of authoritative knowledge (Fiedler 1997).

### **7.3.6 What Do Women Interpret as Making Birth Safe?**

This study identifies that doctors and technology are perceived as making birth safe and that women who have experienced a consultant led model of care and birth environment perceive hospital to be a safer place to give birth than home, even though the move from home to hospital births in the 1970's was not substantiated with any evidence (DHSS 1970, NICE 2007).<sup>65</sup>

Women in the study expected the environment to be technological and this was a reason they gave for not wanting to be at home for the birth, they felt safer with technology around them. The women in the study interpret technology and doctors as preventing problems in childbirth, when there is a body of evidence showing that unnecessary interventions performed in hospital cause complications, including operative birth and poor outcomes for mother and baby (NICE 2007). Only one of the women (Sally) experiencing consultant led care felt safe with a midwife and would have a homebirth next time, whereas all of the women experiencing midwifery led care would consider a homebirth next time.

This study builds on the foundations laid by Lavender and Chapple (2002) who found that women perceived that hospital was a safer environment to give birth to their babies. This finding was not related to a model of care or birth environment, as the study used a cross section of women and midwives in their study. It did not identify why women thought birth was safer in hospital. Houghton et al (2008) found that women, midwives and obstetricians thought hospital was a safer environment to give birth than any other environment when they were investigating choices of place of birth, but they did not identify the model of care this was related to.

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<sup>65</sup> See chapter 2, section 2.2.5.5 for further information.

## **7.4 HOW HARAWAY HELPS US TO UNDERSTAND PERCEPTIONS OF A MIDWIFE'S ROLE**

In this study I have drawn specifically from Haraway's writings on: situated knowledges, modest witness, material- semiotic and cyborg (1987, 1991, 1997). I have made references to other parts of her theory through this thesis, as other aspects are related to the findings but none as strongly as modest witness, material- semiotic and cyborg. Therefore, in this section I will concentrate on these three notions of Haraway's theory.

### **7.4.1 Modest Witness**

The modest witness is able to acquire power to establish matters of fact, even though these may be based on no proof or evidence. My interpretation is that the modest witness builds its own world established through its own authority, but does not have to be based on truths. For example, the authority of the CTG machine for women, midwives and obstetricians presents one version of truth about well being that is prioritised above all other witnesses (i.e. testimony of the women in relation to fetal movement). The modest witness may also use what they believe to be true from the evidence they use, but it depends on where the evidence maker and the modest witness are situated.

I propose that the 'being' midwives are modest witnesses of the natural and normal, supported by hundreds of years of survival from 'mother nature' and countless evidence. These modest witnesses continue to disseminate their truth within the culture of the model and environment, which appears to support technocratic medicalised birth. The 'doing' midwives are modest witnesses of the technological and medical, therefore they are able to function much more freely with the technocratic medicalised birth culture of the consultant led environment and model of care that they are in tune with and within which they function. The culture has been produced by the other modest witnesses of the technocratic medicalised birth machine, which appears to be the doctors who are followed by the 'doing' midwife co-ordinators in the consultant led birth

environment<sup>66</sup>, who are 'doing' midwives, but have gained increased managerial and institutional power. This then influences the practice of the other midwives. Not all of the co-ordinators were identified as 'doing', some were recognised as 'being'. Although there is no evidence within the study, they too may feel compromised into 'doing', in the same way as the midwives who want to practice 'being'.

The 'doing' modest witness relies on technology, an interventionist culture and fosters a reliance on pain relief, encouraging more epidurals. This breakdown of the woman's body into parts that need to be controlled has 'over ruled' nature. This has essentially been derived from the masculine hijacking of the birth process, which at the time was welcomed by women (see chapter 3, section 3.2.2 relating to pain relief in labour).

*" Masculine authority, including the seventeenth-century gentlemanly culture of honour and truth, has been widely taken as legitimate by both men and women, across many kinds of social differentiation"*  
(Haraway 1997:28).

By using masculine authority men invented obstetrics<sup>67</sup>, which firmly became the controller of birth, rather than nature. More doctors were needed to provide obstetric care. More intervention breeds more intervention, therefore requiring more doctors. Promotion of the technocratic medicalised birth culture is promoted as it provides more work and more jobs for those providing technocratic medicalised care, which due to the rise in reliance on pain relief especially epidurals, now requires anaesthetists to have a power sharing influence over the birth process. This then requires the service to recruit more anaesthetists and obstetricians to cope with the increase in interventions. The medical influence then becomes stronger and the doctors then hold power positions within the organisation. They can then hold the organisation to ransom to protect and employ more of them. The doctors diminish the autonomy of the midwife and steer control of the midwife's role through controlling what they are allowed to do. They disable the 'being' aspects of the midwife so their only

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<sup>66</sup> Not all co-ordinators are 'doing' midwives, some are 'being' midwives, although they are few. Within the culture it is more likely for a 'doing' midwife to be promoted to the status of 'co-ordinator' than it is for a 'being' midwife.

<sup>67</sup> See chapter 2, section 2.2.3.

function is 'doing'. The midwives who perform 'doing', gain praise and recognition within the technocratic medicalised birth culture. The future may see all midwives as obstetric nurses, so that they just 'do'. Drawing on my own experience, I recall a senior midwifery manager told a group of student midwives that if they wanted to be employed they were not expected to 'think', they needed midwives to 'do'. This was at a time when midwifery numbers had been reduced due to cost cutting by the institution, but interestingly more obstetricians were being employed. The 'doing' philosophy appears to be supported throughout the institution.

The 'being' midwives are the modest witnesses of the natural and normal millennium, they are restricted in their function by the technocratic medicalised birth culture, which are prevented from 'being' and coerced into 'doing'. The influence projected by some of the labour ward co-ordinators, those that appear to practice 'doing' and the doctors as modest witnesses of the technocratic medicalised birth machine, try to convert other practitioners. The midwives influenced by this then become 'doing' midwives, who in turn become modest witnesses of the medicalised birth machine. I have worked with some obstetricians who do support 'being' practices, therefore doctors may also fall into two types of practitioners, but this consideration and proposition goes beyond the scope of this study.

The 'being' midwives do not give up; they are still there waiting for their chance when they are not restricted by the culture. The future maternity service needs to support ways of working and birth environments that provide opportunities for 'being' midwives to practice within a culture and environment that supports them. There was a stark warning within the midwives' data that there will be no 'being' midwives left within the technocratic medicalised birth culture, as they feared that they 'being' midwives are either leaving the profession or finding environments and models of care which support their 'being' philosophy and which provide them with greater job satisfaction. There may be no 'being' midwives left, if we do not take action now.

#### **7.4.2 Material-Semiotic**

Crozier et al (2007) recognised that midwives communicated with machines. This study goes a step further by applying a connection between midwives to Haraway's concepts. It also identifies connections with the women in this study and machines. Women experiencing consultant led care and midwives working within a consultant led model of care and environment used material-semiotic connections in relation to technology. Women particularly conversed with scan machines and CTG machines. They felt comforted to have them near and liked to connect with their baby through them. They did not seem aware of connecting with their baby through their own body, linking baby, body and soul as within a biological, physiological network. This is also a finding found by Kingdon (2007). Linking to machines in this way is a characteristic of a 'cyborg', therefore I have analysed the features of a cyborg and applied them to the findings of this study.

#### **7.4.3 Cyborg**

Haraway (1991) summarises the cyborg theory as a way of thinking, which transcends the boundaries of humans and machines, enabling creative possibilities for the future where there is no gender and where identities are not unitary. Donna Haraway's cyborg manifesto (1991) reflects on the blurring of humans and technologies, out of which comes new subjectivities and meanings. Cyborg is a cybernetic organism, hybrid of a machine and organism. She does not relate the cyborg to childbirth in her concept of the cyborg in the manifesto (Haraway 1991), but later on in her work on 'virtual speculum' in *Modest\_Witness@Second...Millenium.FemaleMan© Meets...OncoMouse™* Feminism and Technoscience (Haraway 1997) she alludes to the woman in pregnancy being a cyborg. In Davis-Floyd and Dumit's (1998) anthropological work entitled 'cyborg babies' they provide an association with Haraway's (1991) cyborg theory. They connect individual technologies (Rapp 1998, Cartwright 1998) and technocratic birth (Davis-Floyd 1998) to the theory of the cyborg (Haraway 1991). These associations are based on anthropology, whereas my

study enters the debate using associations from a different angle. Arguably the cyborg concept is evident in this empirical study, relating not just to women as in Davis-Floyd and Dumit's (1998) work, but also in relation to the role of the midwife, providing a unique relationship and an original contribution to knowledge of this theory.

Women and midwives use technology to their own advantage within the findings of this study. They connect with them through cybernetic connections of the material-semiotic (as described in the previous part of this section, 7.4.2).

Midwives within a consultant led model of care and environment appear to be unable to function without the machines. It is essential in connecting with the baby, finding out what is happening inside. The midwives feel unable to provide measurements and 'doing' activities without them. The machines act as a midwife themselves, 'caring' for the woman while the 'real' midwife is called away from her. When the machine is not used, as her replacement the midwife perceives it as an extension of herself, as an extra arm, connected to her body. The machines provide evidence to protect the midwife and doctors from litigation, as they provide measurements. Machines are therefore, perceived as essential in providing 'safe' maternity care, even though evidence does not support this (NICE 2001, 2007; Kings Fund 2008)<sup>68</sup>. Cartwright (1998) describes the CTG machine as a biomedical technology, arguing that it is viewed as able to penetrate the womb, which makes the womb and baby accessible. Obstetrical decisions are made on the output of this machine and appropriate treatments are then prescribed. She states:

*"Obstetrical practitioners are responding through the learned obstetrical doxa which is reinforced judicially through malpractice lawsuits. Practitioners are responding not only to their human patient but also to the monitor as it represents the patient. They are responding to the unity, to the cyborg"*  
(Cartwright 1998:244).

She argues that practitioners view women as cyborgs, but I argue that within my study there is evidence that the midwives and the women are both cyborgified within a consultant led model of care and environment.

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<sup>68</sup> See chapter 2, section 2.2 for further details.

Midwives use machines as replacement midwives. This practice may be from other influences, for example, by midwife co-ordinators, because they are struggling to provide one to one care on the shift. The co-ordinators know that there are not enough midwives for the ratio of women to give one to one care; therefore they look for alternative sources of workforce; employing the machine as an honorary midwife resolves the issue. The midwives interact with the machines as if they are connected to them, as if they think as one person, functioning as a 'cyborg'. The 'doing' midwives act as cyborgs intuitively; they perceive their role as a cyborg. The 'being' midwives try to resist the role of 'cyborg'. The institutional control, governed by the technocratic medicalised birth machine, expects her to be 'doing'; therefore, she is forced into working as one. She does this for her own advantage within this culture, to retain her job and also to try to influence the natural and the normal through her cyborg activities. Therefore, she sort of acts as a 'spy', interpreting the culture that is going on around her, but also trying to influence the 'being' aspects of her nature and promoting the natural and the normal with both women and other midwives, trying desperately hard to provide an holistic paradigm. This finding and interpretation using Haraway's (1991) cyborg concept is the most valuable finding within this study for me. I also find the application of the cyborg-goddess concept extremely exciting and insightful in helping to understand the function of midwives working in a consultant led model of care and environment.

Haraway (1991) said that she would rather be a cyborg than a goddess; I interpret the 'being' midwives, along with myself preferring to be goddesses rather than cyborgs, even though we are functioning as cyborgs. Davis-Floyd (1998) also prefers to be a goddess, she states:

*"I would rather be a goddess- a fully embodied woman, who knows that she IS her body, who accepts herself, her sexuality, her femininity, and her creativity, and whose life is an expression of that"*

(Davis-Floyd 1998:267).

The women who accessed midwifery-led care and one of the consultant- led women appeared to be embodied, working with the natural and normal, encouraged by the influence from their midwives. They too appeared to accept



themselves as 'goddesses' and resist the call to be 'cyborgs'. These women were aligned to the holistic paradigm discussed by Davis- Floyd (1995) suggesting that the body is a field of energy in constant interaction with other energy fields. This is supplementing the fact healing requires attention to the body, mind, spirit, community and environment. This paradigm insists the pregnant woman and child are as one, inseparable. Too many technological interventions make birth dysfunctional and cause the problems they were created to resolve. When women are nurtured and protected they give birth best, as this allows their bodies to set the rhythm and tone for birth with no one else's timetable or rhythm overriding it. The women experiencing this model of care viewed the midwives as supporting this paradigm and assisted them to embrace it. The women and midwives within this model could be interpreted as 'goddesses'. I am not trying to allude to goddesses being any better than a cyborg, just to their differences and the application of these concepts of Haraway's (1991, 1997) theory to this study. Women can situate themselves between both, moving between goddess and cyborg, as in the way the 'being' midwives do in the consultant led model of care and birth setting.

The majority of women experiencing consultant led care wanted to view inside their body to see and relate to their baby, as they are disembodied; therefore, they are not able to relate to the baby from within them. The machines give them contact with their baby. They view the machine as an extension of themselves. It is something that they perceive as giving them wholeness. They know that access to the machine is controlled by the doctor, therefore engage and negotiate with the doctor to enable this access. The midwife applies the machine if instructed by the doctor, either through instruction or via protocols and guidelines. The women relate the technology and conform to the model of care as a way of connecting with their baby. They have to become a cyborg for the connection to happen. There is an expectation that by conversing with the machines, becoming a cyborg, they will be 'rescued' by its readings and measurements, allowing them to have surgical intervention, which will free them from the birth process. They are also aware of the relationship of the midwife and doctor with technology.

Women within this technocratic medicalised birth environment observe the midwives and doctors conversing with the machine and perceive its importance within this culture. They therefore, use this information to their own advantage, so want to converse with the technology themselves. They are only able to converse with the machine through permission to access it through the doctor. The doctor gives the permission for the midwife to connect them to the machine. The machine allows them to connect with their baby. This is why women experiencing consultant led care perceive hospital birth to be safer than homebirth, because they are thinking as cyborgs. If you asked the 'doing' midwives which environment for birth is safer they would probably agree with this, as they function as cyborgs too. The technological environment becomes of paramount importance in supporting pregnancy and birth. Houghton et al (2008) also found evidence of this.

Within this study consultant led women are cyborgs themselves and perceive midwives as cyborgs. 'Doing' midwives in this study are cyborgs and perceive women as cyborgs. 'Being' midwives are forced into being cyborgs; when they want to naturally be a goddess, therefore move between both. Because midwives and women are conforming to the technocratic medicalised culture they are within, 'being' midwives want to view women as goddesses. To compound this belief within the pressure from the culture, the women have become cyborgs. The 'being' midwives recognise this and it causes personal frustration to them. This is the most significant and important relationship of my study with the concepts of Haraway (1991, 1997).

## **7.5 CONCEPTUALISATIONS OF A MIDWIFE'S ROLE**

This study contributes to the body of knowledge of perceptions of a midwife's role, both with original evidence and similarities to other knowledge. The conceptualisations of a midwife's role are now discussed.

This study has found that midwives can have an influence on women's empowerment within a midwifery led model and birth environment. Women who experienced this model and environment, plus one of the women experiencing a consultant led model and environment, knew the process of normal physiological birth and worked with the process, rather than expecting to be

'rescued' from it. These women were experiencing a holistic paradigm, described by Davis-Floyd (1995). They perceived the midwives' role as promoting and working within this paradigm and perceived the midwives caring for them to have 'being' characteristics.

Midwives who had 'being' characteristics were also working within a consultant led model of care and birth environment, but felt forced into 'doing' by the technocratic medicalised birth culture they were practicing in. While complying with the 'doing', they were also trying to promote the holistic paradigm (Davis-Floyd 1995) with women and midwives 'behind closed doors'. They were frustrated that the expectation of women was for them to be 'doing', due to the influence from society and from their observations of the midwife's role within this model of care and environment. Midwives that want to do 'being' and the midwives who are 'being' are modest witnesses of the natural and normal, a promoter of the holistic paradigm, when related to Haraway's theories (1997). They are 'goddesses' rather than 'cyborgs', when related to Haraway's (1991) cyborg theory. If they are forced into 'doing' they become cyborgs to comply with the technocratic medicalised birth culture they find themselves having to function within. In this way 'being' midwives can permeate both theoretical concepts, fluidly transferring between both. The midwives who enjoyed 'doing' worked in synchronised harmony with the technocratic medicalised birth machine culture they were experiencing within a consultant led model of care and environment. They worked as one with the technology and medicalisation, working as 'cyborgs', machines were their extra arms; an essential component of midwifery care. There was evidence that machines were sometimes used as a replacement midwife, a midwife 'clone'. This builds on the work by Crozier et al (2007). The 'doing' midwives, some of whom are co-ordinators of this environment are modest witnesses of the technocratic medicalised birth machine, along with the doctors, who promote the use of interventions and technology to control the unpredictable normal birth process that does not run to institutional timings and demands.

Media coverage of childbirth and observations of midwives within their role by women provide differences perceived by them on the function of the role the midwife plays in maternity care. Women experiencing midwifery led care and

one of the women experiencing consultant led care, felt equipped to cope with the normal physiological process of birth, due to the influence midwives had on women's empowerment to 'do it', 'get through' the process themselves. They experienced 'being' characteristics from the midwives who cared for them, which supported a holistic paradigm and appeared to be embodied.

The women experiencing a consultant led model of care and environment expected midwives to be 'doing'. They viewed integrating with machines as an intricate part of the midwives' role. The majority of the women viewed themselves as disembodied, happily accepting offers of repair to their bodily parts from doctors. Women perceived midwives as 'handmaidens' to doctors, evaluating that it is doctors who make the decisions within this technocratic medicalised birth culture. Midwives agreed; reluctantly even the 'being' midwives agreed that doctors make the decisions within this culture. To gain access to the machines women perceived that they needed to gain permission from the doctor for a machine to be applied by a midwife. They appeared to agree to interventions and medicalisation prescribed by the doctor to gain access to the machines, which allowed them to connect with their baby. The majority of women within this model of care and environment perceived that because they are disembodied and cannot connect with their baby through their body, mind and soul, they could only connect through the medium of machines. The technology gave them reassurance of their baby's wellbeing. Women experiencing a consultant led model of care and environment use the machines to their own advantage. They view the machine as providing a connection between them and their baby; they are thinking and functioning as cyborgs. Women perceive the presence of doctors and technology as making birth safer, which supports the work by Houghton (2008), even though evidence does not support this (NICE 2007). They perceived one of the main roles of the midwife to be providing pain relief and there was an expectation that doctors and midwives would 'rescue' them from the normal physiological birth process by intervening and 'making it stop'.

This study supports the assertion by Lavender and Chapple (2002) that there are two types of midwives. It also supports their finding that women perceive hospital birth to be safer than homebirth. However, these researchers failed to

delve further into the reasons why women perceived this as this study has. Houghton (2008) also found women, as well as midwives and obstetricians perceived birth to be safer in hospital, but the study did not delve any deeper as it was focused on choices of place of birth.

Walsh (2007a) describes the midwives functioning in the birth centre as promoting the natural and normal, working within a holistic paradigm. Walsh (2006) also describes finding 'matrescent' and 'nesting' care being provided by the midwives in a birth centre, which has some similarities to the influence midwives had on women's empowerment, but is essentially different.

This study identifies two types of midwives. McCrea (1998) describes three types of midwives specifically in relation to pain relief, which adds insight into the findings of this study. Hunter (2005a) describes midwives as functioning differently depending on the environment they are working within. This study goes a step further by its relation to Haraway's (1991, 1997) writings of the modest witness and the cyborg.

Women expected doctors and midwives, not only to rescue them with pain relief, but also expected to be rescued by intervention and surgery. Leap and Anderson (2004, 2008) relate pain relief as a type of 'rescuing' of women from the normal physiological process, but my study findings show that this is only a characteristic with women experiencing a consultant led model of care and environment.

## **7.6 STRENGTHS AND LIMITATIONS OF THIS STUDY**

I have identified factors that influence interpretation of the midwife's role by women and midwives, to logically reason how they 'come to know'.

The strengths of this study lie within the concept of two types of midwives 'being' and 'doing'. By exploring my findings from this study with Haraway's (1991, 1997) theories two prominent links became apparent. The identification of two types of 'modest witnesses': one that promotes the natural and normal, the midwives that practices 'being'; the other supports the technocratic medicalised birth culture along with the doctors, these midwives practice

'doing'. The application of 'goddess' is appropriated to the 'being' midwives for when they are practicing 'being' and cyborg to the 'doing' midwives. The fact that 'being' midwives can mutate from a 'goddess' to a 'cyborg' to adapt to environmental pressure from the technocratic medicalised birth machine is an important finding. This is the most unique finding within the interpretation of Haraway's (1991, 1997) concepts to the findings of the study. This is my most important contribution to knowledge.

Another strength is the difference in women's engagement with the normal physiological process, which appears to be related to the model of care and birth environment they are within. Women experiencing a midwifery led model of care and environment were empowered to 'get through' the normal birth process by the influence of midwives. They knew, understood and connected with the normal physiological process through their mind, body and soul. Whereas the majority of women experiencing a consultant led model of care and environment did not 'know' the normal physiological process and did not connect with it. Instead they connected with machines and expected to be 'rescued' from the normal birth process through pain relief, intervention or surgery. They wanted the process to be 'taken away' and interpreted the process as being 'too long'.

The limitations of this study lie in the fact that I was unable to gain the views of the midwife co-ordinators within the consultant led environment; the co-ordinators may have a large influence on the culture of the environment. I anticipated that some of them would have been at the birth of the women experiencing the consultant led model of care and birth environment in this study, but this did not occur.

My role as a consultant midwife in normality, which was known by all of the midwives, may have influenced their responses at interview. Personally I was surprised how honest the midwives appeared to be and I did not feel in any way that it limited their responses, it actually felt like a strength. I had not met any of the women previously and I introduced myself as a researcher, therefore I did not perceive that my role influenced their responses, but it may have been, therefore I am identifying it as a limitation.

## 7.7 CONCLUSION

This study has shown how women and midwives 'come to know' (Kingdon 1998) the role of the midwife. No single knowledge prioritises above another. Where the women and midwives are situated depends on how they manipulate and adapt to the situation and culture they are in. The women and midwives know that the culture is based on the technocratic medicalised birth machine and adapt the way they function within it to obtain what they need. The midwives do this to keep their jobs and some enjoy their job within the present culture. While the women do this to get through this childbirth experience, some enjoy the experience too.

Be it a cyborg or a goddess they both have limitations and strengths. What is revealing and the most important part of the study in relation to Haraway's (1991, 1997) concepts is that the 'being' midwives working within the technocratic medicalised environment reluctantly work fluidly between goddess and cyborg, acting as a goddess when 'no one is looking'; like a chameleon mutating from one to the other to fit the situation.

For change to occur in the 'hearts and minds' of women, a whole shift is necessary that supports the normal birth process rather than technocratic medicalised birth. The women's experiences and observations of the midwife's role are gained from their own personal experiences and those shaped within society. Society as well as providers and commissioners of maternity care need to become focused on a shift to support normal physiological birth. Only then will we see changes to the whole perspective of childbirth. This change is slow and tortuous. A start would be supporting midwifery led environments, where goddesses can be free to influence women's empowerment of the normal physiological process. Downe and Mc Court (1994) discuss how most outcome measures within maternity services are focused on morbidity and health care systems generally are focused on pathology. They advocate that maternity

services should be focused on a wellbeing perspective; 'salutogenesis'<sup>69</sup>. A move towards a wellbeing perspective rather than an illness-orientated culture would provide a universal change (Downe and Mc Court 2004), which can only be done by commitment and policy change across obstetric and midwifery thinking.

We need women to know that their body and soul are connected and the institution and society need to support this. We need to work swiftly to prevent loss of any more 'goddesses' from the midwifery profession.

I have discussed the findings in relation to original and similarities to other knowledge. Connections have been made to Haraway's (1991, 1997) theories in relation to her writings of the 'modest witness', the 'material-semiotic' and the 'cyborg' with the findings from perceptions of women and midwives, relating to the role of the midwife. I have outlined the strengths and limitations of this study and what we now know about perceptions of the midwife's role.

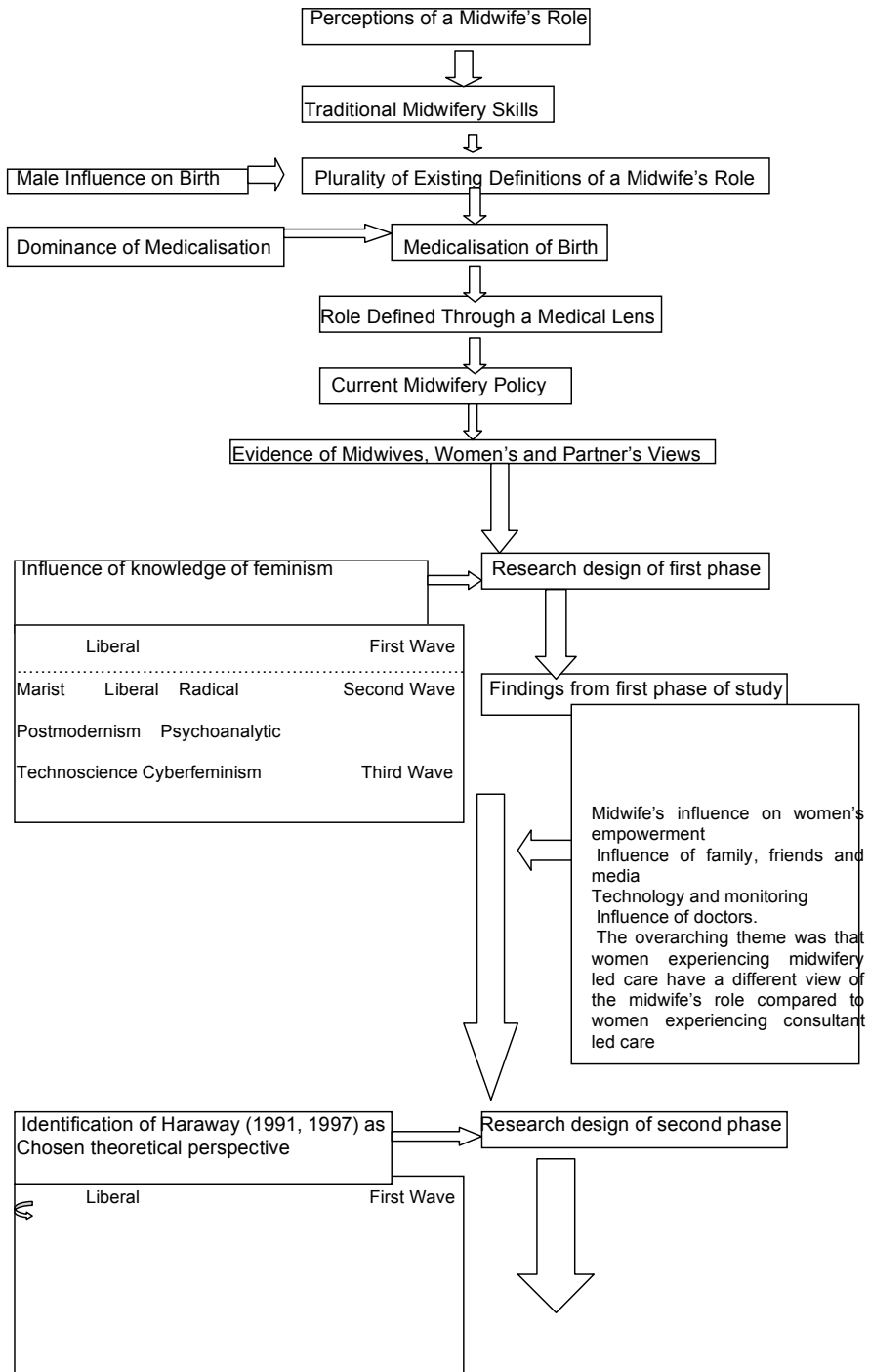
An understanding of the findings from the study, have been provided through this discussion, relating to other knowledge and Haraway's (1991, 1997) notions. Chapter 8 will now move to the way forward from this thesis. Figure 7.2 provides evidence of how my research journey has developed over the seven chapters so far.

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<sup>69</sup> See section 2.2.7



**Figure 7.2 Research Journey**



.....  
 Marxist    Liberal    Radical                    Second Wave  
 .....  
 ↓  
 Postmodernism    Psychoanalytic  
 .....  
 ↓  
 Technoscience    Cyberfeminism

Haraway's theories:  
 Situated knowledges/ partial perspective  
 Diffractions

Findings from second phase

The focus of maternity care is portrayed as being medically led, technological and does not value the normal birth process.

- Women
- Technology is an important part of the midwife's role.
  - Hospital is a safer than home to give birth.
  - Expect environment to be technological.
  - Influence of television programmes (show technological birth).

- Midwives
- Value technology.
  - Women value technology.
  - Machines used as a replacement midwife/babyminder.

**Original Knowledge:**

A midwife is needed throughout childbirth experience

Women and midwives experiencing or working within a consultant led model/ birth environment perceive the focus of maternity care in society as medically led, technological and the normal birth process is not valued.

Midwives working in a midwifery led model of care and birth environment influence women's empowerment of the physiological normal birth process.

Majority of women experiencing a consultant led model of care and birth environment do not understand the normal physiological birth process, or choose not to engage with it. As a result of this women expect to be 'rescued' from the normal physiological birth process.

Technology is valued by women and midwives within a consultant led model of care and birth environment.

**Similarities to other knowledge:**

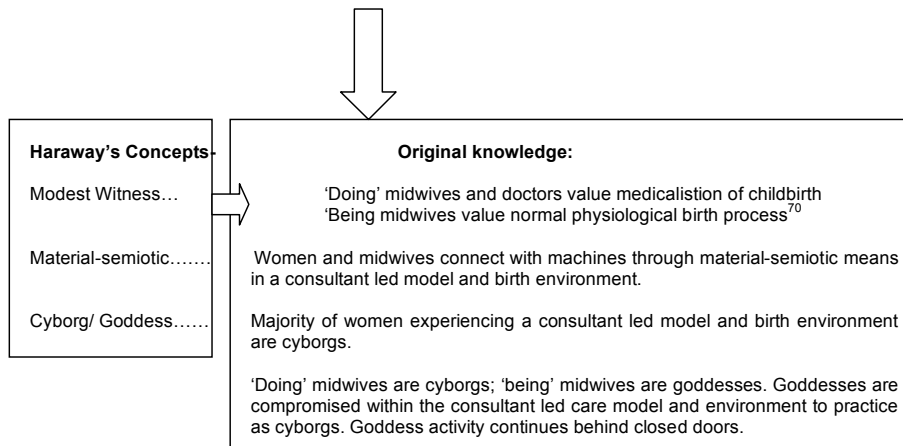
Two types of midwives.

Women are influenced by what they see and read in the media regarding the role of the midwife and childbirth.

Majority of midwives valued the normal physiological birth process.

Women and midwives value technology.

Birth is safer in hospital



<sup>70</sup> The 'being' and 'doing' midwives embody opposite ends of a continuum, but the 'being' midwives move with more fluidity across towards 'doing'.

## **CHAPTER 8**

### **FINDING THE WAY FORWARD**

#### **8.1 INTRODUCTION**

This concluding chapter considers the implications for further research and how this knowledge can inform a view to change the focus of the maternity services from an abnormal paradigm to a focus on well being and to provide equilibrium. There are times when medical intervention is necessary, but presently the balance appears to be tipped too far that way and is influencing normal childbirth. This has led to perceptions that medical intervention is normal. In the following section I present suggestions of how the findings in this study can be carried forward to make change happen or lead further investigation.

#### **8.2 TAKING ELEMENTS OF THIS THESIS FORWARD**

##### **8.2.1 Midwives Leading Care: a key to influencing women's empowerment**

Building on the data found relating to the influence of midwives on women's empowerment and the discussion surrounding this,<sup>71</sup> Kanter's empowerment theory, used in Laschinger et al's (2010) model provides a framework for implementing a structured way of bringing an empowerment influence into maternity care provision. This theory, for both women and midwives in all models of care and environments, could be used to help women believe in themselves to get through the normal physiological birth process and to provide greater job satisfaction for midwives.

Providing environments for birth with care led by midwives can also provide an influence by midwives on women's empowerment as found in this study. This would change how women perceive the normal birth process and how they view the midwife's role. This evidence adds to the resounding amount of evidence already available (Flint et al 1989, Page et al 1999, Sandall et al 2001, Cooper

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<sup>71</sup> See chapter 7, section 7.2.1

2004, Walsh 2007a, Sandall et al 2008, Davis-Floyd et al 2009) and how midwifery led care and midwifery led environments improve midwives' job satisfaction (Ball et al 2002, Walsh 2007a). Disseminating the evidence from this study will help to support midwives, maternity care managers, consultant midwives, chief executives of PCTs and hospital trusts to provide these environments for the advantages of both women, midwives and for cost effectiveness.

### **8.3 INFLUENCING THE POLITICAL AGENDA**

To change perceptions about the role of the midwife there needs to be influence on the political agenda.

From the findings it was evident that, within a biomedically focused model, the focus of care by the midwife was based on the principle of 'doing'. This was influenced by an environment based on technology and medicalisation. This model of care and setting encourages midwives to engage in the 'doing' principle. For women and midwives entering or practicing in a technocratic medicalised culture it is first necessary to change the focus and perspective of birth before perceptions of the midwife's role can be focused further towards an equilibrium of normality and the technological. The caesarean section rate for the U.K. increased to 24.6% (NHS Information Centre 2009), which is an indicator of increased intervention and operative birth occurring nationally. These statistics and the findings from this study confirm that the technocratic medicalised birth machine continues to dominate maternity care.

Maternity Matters (2007a) promised choice for women and the provision of midwifery led environments by the end of 2009. This promise has not been forthcoming in many hospital trusts and PCTs, many still do not offer women choice. Investing in these environments would promote the normal physiological birth process and in turn reduce the caesarean section rates for the U.K.; therefore investment in these environments would pay the trusts (PCT and hospital) back as it would reduce costs<sup>72</sup>. A recent Cochrane review investigating midwifery led care (Sandall et al 2009) show the increased benefits of a midwifery led model of care. Resources should be directed to

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<sup>72</sup> See chapter 2, section 2.2.6.1, for further information .

ensuring all women with no complications can access this model, including referring women fluidly from a consultant led model if complications have been resolved at any point in their pregnancy, so that they too can benefit from midwifery led care. The findings from this study can help influence the agenda to change the current position.

Consultant midwife posts in normal birth are often a token to the promotion of normality. One consultant midwife in normality, is often up against changing the medicalised culture by at least eight obstetric consultants in one trust, some of whom will be promoting technocratic medicalised birth. More commitment is needed from maternity care providers to ensure there are enough consultant midwives to make a shift in the culture or at least be well supported by maternity managers and obstetricians who support the culture shift. By midwives, managers, consultant midwives, obstetricians, accountants and educationalists working together to change the structure of how care is delivered a significant change can be made. An example of this is in Calderdale, where the whole team are working together for the same aims of increasing normal birth and reducing technocratic medicalised birth throughout the region (Shallow 2009). Within the hospital trust I currently work the caesarean section rate has decreased over a five year period from 35% to 25%. This has been achieved by working with midwives, support staff, managers and obstetric colleagues. We have influenced and changed practice across all staff groups, but we still have a long way to go. We have also worked hard to change how we educate women about birth and motherhood, providing particular attention to women who have previously had a caesarean section.

The findings show that the technocratic medicalised birth culture dominates the priorities within the environment. The Maternity Care Working Party (2007) have provided a consensus statement from the National Childbirth Trust (NCT), Royal College of Midwives (RCM) and Royal College of Obstetrics and Gynaecology (RCOG), which helps recognition, facilitation and auditing of normal birth. Midwives, managers, obstetricians need to ensure interventions are not part of normal birth statistics. The facilitation of this document is an important tool in helping increase support for the normal physiological process. This needs to be supported by collaborative investment within institutions, for

example, investment in communication systems, which interface with each other. To increase normality and to reduce the influence of the technocratic medicalised birth culture, an urgent review is needed of the tariff for payments by results (Department of Health 2008). Currently there is a perverse incentive for institutions to increase the caesarean section rate, as more funding is allocated from the PCT for this than a normal birth. Securing power positions for midwives within institutions is an urgent necessity if the normal physiological birth process to be protected<sup>73</sup>. Clinical Director posts should be opened up to include applications from midwives.

This study shows that benefit could be gained by increasing resources into ensuring women are engaged with the normal birth process, so that they understand it and work with the process rather than against it in labour and birth. Midwives need to be aware of the influence they can have on women's empowerment. This study indicates that a midwifery led model of care is of benefit and that a model ensuring continuity can provide advantages for both women and midwives in relation to this aspect.

The findings show that some of the 'being' midwives felt unsupported and were looking to leave settings that are subject to the constraints of the technocratic birth culture. 'Being' midwives need to join together to support each other through initiatives like the Campaign for Normal Birth (RCM 2005) that help apply political pressure for change to occur. Midwives can access the site for help and advice on promoting normality within their institution.

Women are influenced by what they see in the media. Kingdon (2008) found that newspapers are now reporting on the disadvantages of caesarean birth. The media, especially television programmes do influence women's perceptions of the midwife's role and of contemporary birth culture. Midwifery groups, for example, the Royal College of Midwives, need to ensure they are the first point of access for the media in relation to birth and the role of the midwife to promote a natural and normal perspective of pregnancy and birth as life events.

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<sup>73</sup> See part one of Chapter 2 for information about clinical director posts for midwives

## 8.4 MAKING A DIFFERENCE

My aim is to inform others of the findings of this study, which I hope may make a difference to the experiences of women and midwives in the future, I will disseminate the findings and knowledge gained from this thesis to the national midwifery network. By disseminating the findings from this study I can help to make a difference to maternity care provision by awareness of the themes found in this research study<sup>74</sup>. The focus of maternity care needs to move away from the emphasis being on the abnormal. The profession needs to gain supporters of the normal physiological birth process within the media and think about showing the 'being' aspect of the midwife's role, rather than the 'doing' aspects. The media needs to be influenced to change the portrayal of birth from technocratic and medically led to woman centred, normal and natural, with midwives at the centre of maternity care. This study opens up the debate about the advantages of providing continuity to women. It also highlights the advantages of having an environment for the normal birth process to flourish in. Ideally these environments are birth centres and midwifery led units. There may then become a time when the technocratic medicalised birth machine (biomedicine) retreats and becomes less aggressive, allowing the normal birth process to survive within the confines of the same environment.

Downe and Mc Court (2004) discuss a move towards salutogenesis<sup>75</sup>, where birth is interpreted through a wellness model rather than an illness model. If this model was embraced throughout maternity care this would push aside the technocratic medicalised birth culture and would enable the midwives to practice 'being'. Women need to see 'being' before they perceive the role of the midwife differently. Women need to believe in and want to engage with the normal birth process before their expectation of birth is different. 'Doing' midwives need to see 'being' in practice, the setting needs to facilitate it to 'be', otherwise all they see is midwives 'doing' as the 'being' midwives mutate into a cyborg.

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<sup>74</sup> The combined themes are in chapter 6 section 6.5.

<sup>75</sup> Discussed further in part one of chapter 2



## 8.5 FUTURE RESEARCH

This study opens up possibilities for future research. Unfortunately within this study I was unable to interview any midwife co-ordinators. I perceive that their views are important in relation to midwives practicing 'being' and 'doing' and their relationship with the culture they are working in, especially when related to Haraway's (1991, 1997) theories of modest witness, material-semiotic and cyborg.

I was prevented from carrying out an observational study by the Ethics Committee; this would have added value to this study. A follow on study using observation would add a further dimension to these findings, especially in relation to interactions between health professionals; and between health professionals and women.

It would be interesting to investigate if 'doing' midwives working within a midwifery led culture fluidly cross to adopt 'being' practices. Exploring, to see if the concept works the other way around.

Interviews with obstetricians would enhance the depth of this study to explore how their perceptions of the midwife's role reflect against the 'being' and 'doing' concepts of the findings.

Interviews with the midwifery led women's midwives from the first phase would have been beneficial to explore their influence on women's perceptions in more detail. It was not until I studied the findings that I learnt about this influence. This would be beneficial as a follow on study.

I would like to investigate doctor's perceptions of their role, to see if 'doing' and 'being' doctors are identified. Over my midwifery career I have worked with and been supported by many obstetricians, therefore I perceive that there are different types of doctors within obstetrics too. A study to investigate this would be insightful and build on the knowledge of this study.

Birth partner's views would have been beneficial on their perceptions of the midwife's role. This would contribute to the evidence found within the literature review and would help to probe in more detail on the psychological support women perceived that they had received during labour from their birth partner.

An evaluation of women's views and birth outcomes using the DVD and ipod applications, this is discussed below, as an outcome of the study, would be beneficial. It would be useful to see if it made any differences to how women situate themselves through a longitudinal study when using these resources.

## **8.6 OUTCOME FROM THE STUDY**

### **8.6.1 Technology: a vehicle for influencing a change in perceptions**

As a consequence of what was found in the study regarding how women and midwives value technology I decided to use other technologies to harness this finding and use it as a vehicle to promote the normal physiological process of birth beyond obstetrical technologies in maternity care. Therefore I have used the power of media, the DVD and the ipod, rather than the CTG machine. Holly Powell Kennedy (2009) argues that we should find creative ways to disseminate the messages that women's bodies are to be trusted and that:

*"Birth is a healthy and achievable event within their personal power"*  
(Powell-Kennedy 2009:434).

Educating women about the normal physiological birth process appears to be a way forward to change women's perceptions about the role of the midwife and the birth process. A DVD incorporating information about the normal physiological process and how to prepare themselves for this would be a start in changing perceptions, which would help promote normal birth, reduce interventions and allow 'being' midwives to have more opportunity to 'be'<sup>76</sup>.

The DVD has been piloted by gaining opinions from four focus groups (40 women and birth partners); the findings were: 100% of the women in the focus group felt the DVD provided useful information; 100% felt it should be

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<sup>76</sup> Funding for the making and production of the DVD came from Worcestershire County Council.

distributed to all pregnant women in the county immediately. Following the success of the pilot project Worcestershire County Council is supplying all pregnant women with a DVD over a 12-month period. The County Council have now developed the DVD into a website, which has a link to it from Worcestershire Acute Hospitals Trust, the Royal College of Midwives Campaign for Normal Birth website and the West Midlands Local Supervisors Authority (LSA) website. There is acknowledgement on the website that the idea came from the findings from my research and the film company and County Council have signed a document ensuring the intellectual property rights belongs to myself and the two other contributors.<sup>77</sup> This DVD and website are a direct product from the study.

## **8.7 CONCLUSION**

This thesis is a unique exploration of perceptions of the midwife's role, providing both original knowledge and building on what is already known. It provides longitudinal data, with two phases using different data collection methods. It also mirrored women's perceptions with the midwives who were present at the birth. I now offer some reflection on my experience and my final thoughts.

The past six years have been an enlightening and inspiring journey. I have experienced both joy and sadness as women and midwives have shared their stories with me. I hope to have transferred these insights to the pages of this thesis, while endeavouring to understand the concepts and meanings through my methodology and theoretical perspective.

This thesis is rooted within my own perceptions, my own experiences of childbirth, being a mother, my role as a midwife and promoting normal birth. I have been honest and truthful within this thesis and have explored the issues of reflexivity and my own diffractions. I believe my experiences assisted my immersion into this study and have been a gift to assist my understanding. My colleagues, supervisory team and my family have continually been engaged with the development of this thesis through discussion, assisting my development of this work.

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<sup>77</sup> A copy of these is included in Appendix 6.

I have sometimes found my journey frustrating as I have struggled to grasp hold of methodological matters and theoretical concepts, until I found solace in Haraway's (1991, 1997) notions later on in my quest. I have found her work both compelling, humorous and thought provoking. She has led me into a new world, a new way of 'seeing'. This postmodern feminist technoscience lens was an exciting and revealing aspect.

My approach to this thesis has been filled with passion and has been a rewarding experience. My hope is that this work will go some way to changing the future of the maternity services to make a real difference to both women and midwives' experiences. Now it is time to start a new journey, with all of the resources learnt from this experience packed in my rucksack.

I now return to the findings of this study. This thesis is a wake up call. It identifies that there are two types of midwives, one of which is supported, the other that is neglected within a consultant led model and birth environment. Midwives who want to 'do' are free to practice their cyborg activities. The time is now to recognise the importance of 'being' and its impact on perceptions of the midwife's role. There is room for both, neither are right or wrong. But they should both be free to exist. The word 'midwife' has its origin in Middle English language, 'mid' meaning 'with' and 'wife,' meaning 'woman' (Oxford English Dictionary 2008). Fundamental to the midwife's role is being 'with woman', not with machine or amnihook. There needs to be space for midwives to 'be'.

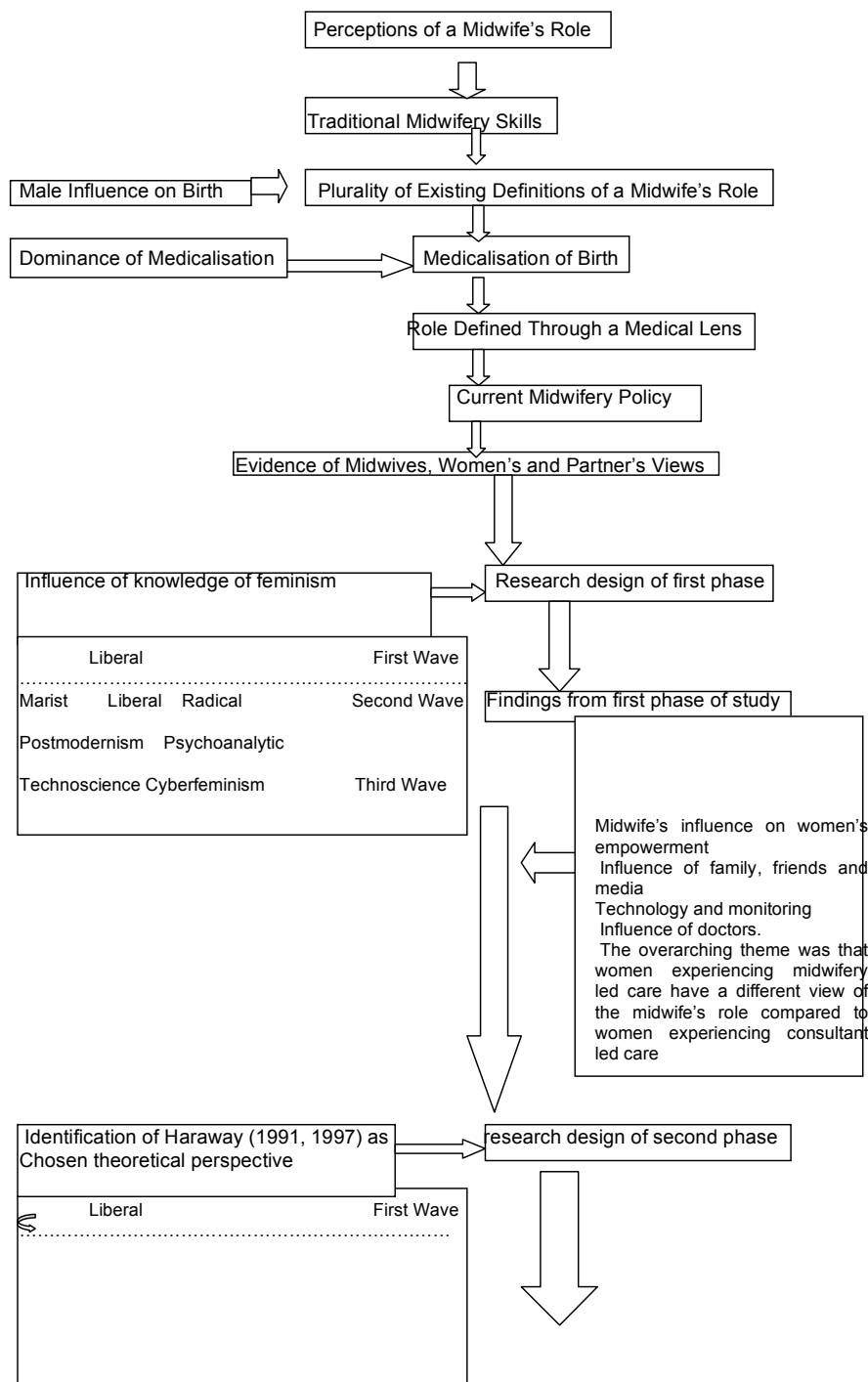
*"Midwives are trying to empower women to give birth as they are, not as the culture wishes to make them."*  
(Robbie Davis-Floyd 1998:274)

There needs to be equilibrium at least. Women and midwives should be free to be a cyborg or a goddess, not seduced by the suffocating culture of biomedicine or have to mutate to be both.

Davis-Floyd (1998) comments that she is disappointed not to see midwives studying aspects of technologised reproduction. This is a contribution to this knowledge written by a midwife for women, birth activists, midwives, researchers and anthropologists to enjoy reading.

Figure 8 shows my completed research journey of this research study and thesis and will remain engrained as a big part of my life. I hope to have given ways in which it is possible to change how the midwife's role is perceived and by changing how women and midwives view birth, we can improve experiences for women.

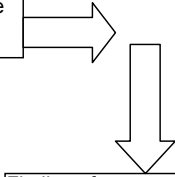
**Figure 8.1 Research Journey**



Marist Liberal Radical Second Wave

↓  
-----  
Postmodernism Psychoanalytic  
↓  
Technoscience Cyberfeminism

Haraway's theories:  
Situated knowledges/ partial perspective  
Diffractions



Findings from second phase

The focus of maternity care is portrayed as being medically led, technological and does not value the normal birth process.

Women

- Technology is an important part of the midwife's role.
- Hospital is a safer than home to give birth.
- Expect environment to be technological.
- Influence of television programmes (show technological birth).

Midwives

- Value technology.
- Women value technology.
- Machines used as a replacement midwife/babyminder.

**Original Knowledge:**

A midwife is needed throughout childbirth experience

Women and midwives experiencing or working within a consultant led model/ birth environment perceive the focus of maternity care in society as medically led, technological and the normal birth process is not valued.

Midwives working in a midwifery led model of care and birth environment influence women's empowerment of the physiological normal birth process.

Majority of women experiencing a consultant led model of care and birth environment do not understand the normal physiological birth process, or choose not to engage with it. As a result of this women expect to be 'rescued' from the normal physiological birth process.

Technology is valued by women and midwives within a consultant led model of care and birth environment.

**Similarities to other knowledge:**

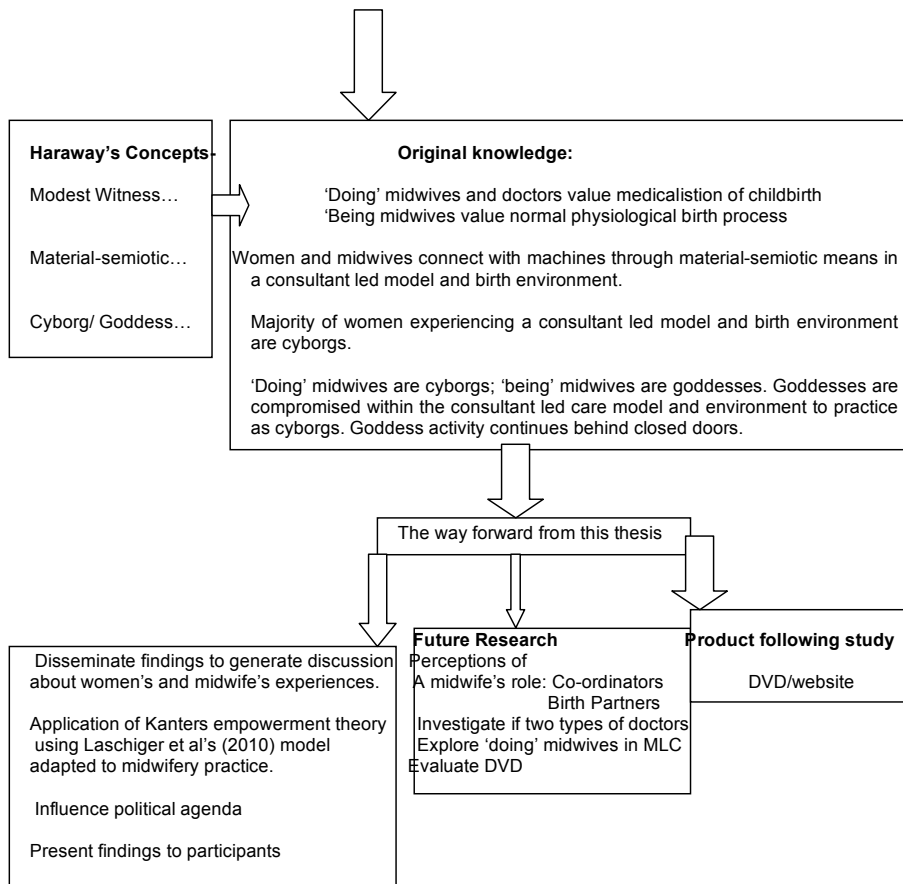
Two types of midwives.

Women are influenced by what they see and read in the media regarding the role of the midwife and childbirth.

Majority of midwives valued the normal physiological birth process.

Technology valued by women and midwives.

Birth is safer in hospital





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**APPENDICES.**

## **APPENDIX 1.**

**Information sheet, consent form, interview schedule  
and Ethic's Committee approval confirmation for the  
first phase of the research.**

## **APPENDIX 2**

**Information sheets, consent forms, interview schedule, guidelines for completion of diary and confirmation of approval from Ethics Committee for second phase of research.**





## **Information about the research**

### **'What women think a midwife does'**

#### **Part 1**

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen if you take part.

Part 2 gives you more detailed information about the conduct of the study).

Ask me if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

The study aims to find out what women think a midwife does, so we can use the information to inform the profession and make service changes if necessary based on the information you give us.

#### **What is the purpose of the study?**

The overall aim of this study is to explore views of women and midwives on the role of the midwife. It will generate understanding of the complexities of how and why women's and midwives views are shaped, in relation to the role. The information will inform practice developments and education within the midwifery profession.

#### **Why have I been invited to take part?**

Anyone who is about 24 weeks in their pregnancy today in ante-natal clinic I am inviting to take part. There will be 12 women in total in the study.

#### **Do I have to take part?**

It is up to you to decide. I will describe the study and go through this information sheet, which will then be given to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at anytime, without giving a reason. This would not affect the standard of care you receive.

What will happen to me if I take part?

I will give each participant a diary to record her interactions with any midwife she meets during the rest of her pregnancy, the birth and after you have your baby.

I will interview at home within 2 weeks of you agreeing to take part, I will then interview you again at home at 36-38 weeks of pregnancy, following the birth and at 6 weeks following the birth.

The midwife who cared for you in labour will also be interviewed about how she views her role.

Interviews will be voice recorded. You will not be identified, names will be changed so you are not recognised. You can choose the name yourself that you wish to be identified with, this includes your diary too. Midwives can also choose a different name, if not their names will also be changed so they are not identified either.

I will collect your diary at the interview at 6 weeks following the birth.

Expenses and payment.

No travelling or expense is required from you, I will come to your house for the interviews. But, it will require 30-60 minutes of your time for each interview and time to fill in entries in your diary following each meeting with a midwife. Midwives will be interviewed in the workplace.

What will I have to do?

Complete a diary entry every time you have any contact with a midwife. Allow me to interview you at home twice in your pregnancy and twice following the birth of your baby. Interview the midwife who cared for you in labour.

What are the possible disadvantages and risks of taking part?

Participants may become upset if they are discussing a difficult experience for them, but this will be dealt with sensitively by the researcher and appropriate further help will be sought.

What are the possible benefits of taking part?

This study will not benefit you at this time but may change service provision in the future and have benefit for others or yourself in the future.

What happens when the research study stops?

The findings of the study will be sent to you when it is concluded.

What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in part 2.

Will my taking part in this study be kept confidential?

Yes, I will follow ethical and legal practice and all information about you will be handled in confidence.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

What if new information becomes available?

I will consider the new information available and if it effects this study. If it is felt that there will be no benefit in continuing the study I will let you know immediately and the study will be stopped.

What will happen if I don't want to carry on with the study?

We will destroy any identifiable information we have about you. We will use the data you have given us up until your withdrawal from the study.

What if there is a problem?

Complaints

If you have any concern about any aspect of this study, inform me as soon as you can by calling 01905-760760 and ask them to page Tracey Cooper, leave them your contact number and I will call you back as soon as I can and I will do my best to answer your questions or sort out a complaint as quickly as possible.

If you remain unhappy and wish to complain formally, you can do this by contacting the sponsor organisation for the research, which is:

Professor John Wilson, Director of Research, University of Central Lancashire, Preston, Lancashire. PR1 2HE. Tel 01772- 894282.

Will my taking part in this study be kept confidential?

Yes. You will not be identified during the study, your name will be changed, you can choose a name yourself if you wish. This applies to all the participants including the midwives taking part. All of the data will be coded and stored. The voice recorded information and diaries will be kept in a locked filing cabinet until analysis of the data has been completed. Extracts of the voice recordings will be used when presenting the study, but no participant will be identified. All of the data collected will then be destroyed, witnessed by one of the supervisory team for the study.

In relation to the midwives taking part in the study:

If any malpractice is disclosed to the researcher by a participant (woman or midwife) she will be duty bound to report this to her academic supervisor and the midwife's manager or supervisor of midwives, to ensure the issue is followed through.

What will happen to the results of the research study?

The results will be published in professional journals and will be fed into practice development and education of midwifery practice.

I will send participants the results of the study when they are completed. Participants will not be identified in any report or publication.

Who is organising and funding the research?

The research is taking place in Worcestershire Acute Hospitals Trust and is sponsored by the University of Central Lancashire. The research is being performed as part of my role as a Consultant Midwife and towards an academic qualification.

Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by the Research Ethics Committee.

Further information and Contact details.

Please contact Tracey Cooper via 01905-760760 and ask switchboard to page me or e-mail [traceycooper@nhs.net](mailto:traceycooper@nhs.net) for any further information about this study.

Further information about research can be found at [www.nresform.org.uk](http://www.nresform.org.uk)





Identification No:

### Consent Form

Title of Project: What midwives think a midwife does

Name of Researcher: Tracey Cooper

Please initial  
the box.

- 5. I confirm that I have read and understand the information sheet (dated 28.2.07 Version 1) for the above study. I have the opportunity to consider the information, ask questions and have had these answered satisfactorily.
- 6. I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
- 7. I understand that data from the diary and the voice recordings will be used to inform the study and may be used in quotations without my true identity being revealed.
- 8. I agree to take part in the above study.

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Name of midwife	Date	Signature
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Name of person taking  
consent.

Date

Signature



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## Information about the research

### 'What women think a midwife does'

#### Part 1

We would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take the time to read the following information carefully. Talk to others about the study if you wish.

(Part 1 tells you the purpose of this study and what will happen if you take part.

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Ask me if there is anything that is not clear or you would like more information. Take time to decide whether or not you wish to take part.

The study aims to find out what women think a midwife does, so we can use the information to inform the profession and make service changes if necessary based on the information you give us.

What is the purpose of the study?

The overall aim of this study is to explore views of women and midwives on the role of the midwife. It will generate understanding of the complexities of how and why women's and midwives views are shaped, in relation to the role. The information will inform practice developments and education within the midwifery profession.

Why have I been invited to take part?

A woman you have cared for during her recent birth experience has been part of this study. I am interviewing each midwife that was present at the birth experience to discover a your views on your role as a midwife.

Do I have to take part?

It is up to you to decide. I will describe the study and go through this information sheet, which will then be given to you. I will then ask you to sign a consent form to show you have agreed to take part. You are free to withdraw at anytime, without giving a reason. This would not affect your employment in any way.

What will happen to me if I take part?

I will perform an interview at home or work within 2 weeks of you agreeing to take part. Interviews will be voice recorded. You will not be identified, names will be changed so you are not recognised. You can choose the name yourself that you wish to be identified with.

Expenses and payment.

No travelling or expense is required from you, I will come to your house or interview you at work, which ever is the most convenient for you. But, it will require 30-60 minutes of your time for each interview.

What will I have to do?

Allow me to interview you at home or at work, once only.

What are the possible disadvantages and risks of taking part?

Participants may become upset if they are discussing difficult experiences, but this will be dealt with sensitively by the researcher and appropriate further help will be sought.

What are the possible benefits of taking part?

This study will not benefit you at this time but may change service provision in the future and have benefit for others or yourself in the future.

What happens when the research study stops?

The findings of the study will be sent to you when it is concluded.

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What if there is a problem?

Any complaint about the way you have been dealt with during the study or any possible harm you might suffer will be addressed. The detailed information on this is given in part 2.

Will my taking part in this study be kept confidential?

Yes, I will follow ethical and legal practice and all information about you will be handled in confidence.

If the information in Part 1 has interested you and you are considering participation, please read the additional information in Part 2 before making any decision.

What if new information becomes available?

I will consider the new information available and if it effects this study. If it is felt that there will be no benefit in continuing the study I will let you know immediately and the study will be stopped.

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Professor John Wilson, Director of Research, University of Central Lancashire, Preston, Lancashire. PR1 2HE. Tel©01772- 894282.

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All of the data will be coded and stored. The voice recorded information and diaries will kept in a locked filing cabinet until analysis of the data has been completed. Extracts of the voice recordings will be used when presenting the study, but no participant will be identified. All of the data collected will then be destroyed, witnessed by one of the supervisory team for the study.

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I will send participants the results of the study when they are completed. Participants will not be identified in any report or publication.

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Who has reviewed the study?

All research in the NHS is looked at by an independent group of people, called a Research Ethic's Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given a favourable opinion by Research Ethic's Committee.

Further information and Contact details.

Please contact Tracey Cooper via 01905-760760 and ask switchboard to page me or e-mail traceycooper@nhs.net for any further information about this study. Further information about research can be found at [www.nresform.org.uk](http://www.nresform.org.uk)

## **Interview schedule**

What does a midwife do?

What does a doctor do?

Who makes the decisions?

Do you think technology is important?

Do you need technology/ machinery in childbirth?

What or who will support you in labour?

What do you think the birth environment should be like?

Do you need a midwife in childbirth?

Do you need a doctor in childbirth?

Do you need your family in childbirth?

What they want / compare to what they need??

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**Guidelines for the Completion of Diary.**

Please write in this diary how you view the midwife's job at each contact visit you have with the midwife at the GP's surgery, home, Children's Centre or hospital.

Please include:

How many weeks pregnant you are.

If she/he did what you expected her/him to do.

Your feelings about the meeting.

Did she/he discuss what you expected?

Did you say what you wanted to say?

You can write in anything you want, there is no right or wrong way.

This diary will remain confidential, the name you asked to be identified with is the only one I will use in relation to this diary.

**APPENDIX 3**

**Women and Midwives Matched Cases from the Second  
Phase of the Research.**

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	Midwife's function	Own values
Terri	Monitor, test, measure Paperwork Technology essential Instructed by doctor	Technology- in touch with baby Midwife is 'doing' Focus on pain relief Detachment from body Birth=technical, scary Influence=TV, family Valued LSCS date for planning Doctor= decision maker Family/partner=psychological/ emotional support
Midwife caring for Terri	Expects 'doing' Looks for machines Expects to be rescued from process	Wants to be 'being', forced into 'doing' Rejects interventionist practices Rejects machines Supports normal physiological birth Feels bullied to conform to medicalised culture

	Midwife's function	Own values
Denise	Monitor, test, measure Paperwork Signpost to groups-community Ignored	Technology- in touch with baby, reassuring Some knowledge on physiological process-antenatal session Birth=Disregarded and degraded, 'felt like piece of meat' Detachment from body Doctor=decision maker Family/partner=psychological/ emotional support
Midwife caring for Denise	Reassuring Keep safe and healthy	Hindered by policies and guidelines Likes 'doing' Enjoys 'high risk' care Technology when appropriate

	Midwife's function	Own values
Danni	Monitor, test, measure Relies on technology Provide pain relief	Technology-baby felt real Birth-scary, knives, scissors, pain Focus on pain relief Midwife= 'doing' Felt 'out of control' Detachment from body Doctor = decision maker Family/partner= psychological/ emotional support Safety= technology, doctors
Midwife caring for Danni	Expects 'doing' Pain relief Expects to be rescued from process	Wants to be 'being', forced into 'doing' Supports normal physiological process

		Rejects interventionist practices Rejects machines
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	Midwife's function	Own values
Fiona	Monitor, test, measure Breastfeeding advice Relies on technology Focus on pain relief	Technology-in touch with baby Midwife= 'doing' Birth=painful Doctor=decision maker Family/partner=psychological/ emotional support Safety= technology, doctors
Midwife caring for Fiona	Reassuring Keep safe	Safety= technology Likes machines Likes 'doing' and 'being'

	Midwife's function	Own values
Sally	Supportive Monitor, measure, test Expert knowledge	Birth= normal physiological process Midwives and doctors= decision maker Family/partner/ midwife =psychological/ emotional support Technology- in touch with baby
Midwife caring for Sally	Expects 'doing' Pain relief Doctor's handmaiden	Wants to be 'being' forced into 'doing' Supports normal physiological process Rejects interventionist practices Rejects machines Feels bullied to conform to medicalised culture

	Midwife's function	Own values
Issie	Care for wellbeing Monitor, test, measure Relies on technology	Technology- reassuring. In touch with baby. knowledge on physiological process of childbirth Partner/family= psychological/emotional support
Midwife caring for Issie	Keep safe Reassuring	Likes 'doing' Likes technology-reassuring

	Midwife's function	Own Values
Jenny	Monitor, test, measure Relies on technology Pain relief	Tests= stressful Doctor=decision maker Technology= safety Detachment from body Birth=painful, scary, legs strung up
Midwife caring for Jenny	Expects 'doing' Pain relief	Wants to be 'being', forced into 'doing' Supports normal physiological process Rejects interventionist practices Rejects machines Feels bullied to comply with

		medicalised culture
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	Midwife's function	Own values
Mel	Monitor, test, measure Expert knowledge Relies on technology Pain relief	Technology- in touch with baby, feels real. Birth-lots of people Birth- felt out of control Doctor= decision maker Partner/family= psychological/ emotional support
Midwife caring for Mel	Reassuring Explain all procedures	'doing' wants to be 'being' Appropriate technology

	Midwife function	Own values
Yvonne	Monitor, test, measure Relies on technology Focus on pain relief	Technology- in touch with baby Safety=technology, doctors Family/partner= psychological/ emotional support Midwife= 'doing' Birth=pain Doctor= decision maker
Midwife caring for Yvonne	Pain relief Relies on technology	Wants to be 'being', forced into 'doing' Supports normal physiological process Rejects interventionist practice Rejects machines Feels bullied to comply with medicalised culture

	Midwife's function	Own values
Amy	Pain relief Relies on technology Instructed by doctors	Technology- in touch with baby Midwife= 'doing' Birth=painful, knives, scissors Family/partner= psychological/ emotional support Doctors= decision maker
Midwife caring for Amy	Pain relief Expects to be 'rescued' from process	Wants to be 'being' forced into 'doing' Supports normal physiological process Rejects interventionist practice Rejects machines Feels bullied to comply with medicalised culture

**APPENDIX 4**

**Awards, Presentations and Publications.**

## **Awards/ Presentations/ Publications**

I am extremely grateful to the West Midlands Strategic Health Authority for awarding me with funding to buy out twelve months of time from my employer to write this thesis.

Abstract *Perceptions of a Midwife's Role: A Feminist Technoscience Perspective* accepted for presentation 13<sup>th</sup> -15<sup>th</sup> May 2011, at the Normal Birth Conference, Grange-over Sands.

Abstract *Perceptions of a Midwife's Role: A Feminist Technoscience Perspective* accepted for presentation 14<sup>th</sup> July 2011, at Women & Midwives: Does anyone want normal birth? Conference, University of Worcester.

Abstract *Perceptions of a Midwife's Role: A Feminist Technoscience Perspective* accepted for presentation 1-3 September 2010 at the Doctoral Midwifery Research Society Conference at University of Ulster, Belfast.

*Perceptions of a Midwife's Role* presented at: Our Home: Birth Centre Conference, 5<sup>th</sup> July 2010, City Hospital, Birmingham.

Data from Chapter 4 of this thesis was presented at Women & Public Health: Turning rhetoric into Action Conference, 2<sup>nd</sup> July 2009, University of Worcester and also at the Baby Lifeline Conference, 14<sup>th</sup> March 2009, University of Coventry.

Sections of Chapter 2 and 4 were presented at Postgraduate Research Study Day, 5<sup>th</sup> October, University of Central Lancashire.

Elements of Chapter 3 were published in:

Cooper, T (2006) The Good, the Bad and the Ugly. *British Journal of Midwifery*.

## **APPENDIX 5.**

**Examples of:**

**Interview transcripts from the second phase.**

**Thematic analysis of the first and second phase.**



## **APPENDIX 6**

**DVD: From Bump to Baby  
Intellectual Property Confirmation  
Website Information Acknowledging Research**