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Being safe practitioners and safe mothers: a critical ethnography of continuity of care midwifery in Australia

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Abstract

Objective

To examine how midwives and women within a continuity of care midwifery program in Australia conceptualised childbirth risk and the influences of these conceptualisations on women's choices and midwives' practice.

Design and setting

A critical ethnography within a community-based continuity of midwifery care program, including semi-structured interviews and the observation of sequential antenatal appointments.

Participants

Eight (8) midwives, an obstetrician and seventeen (17) women.

Findings

The midwives assumed a risk-negotiator role in order to mediate relationships between women and hospital-based maternity staff. The role of risk-negotiator relied profoundly on the trust engendered in their relationships with women. Trust within the mother-midwife relationship furthermore acted as a catalyst for complex processes of identity work which, in turn, allowed midwives to manipulate existing obstetric risk hierarchies and effectively re-order risk conceptualisations. In establishing and maintaining identities of 'safe practitioner' and 'safe mother', greater scope for the negotiation of normal within a context of obstetric risk was achieved.

Key Conclusions and Implications for practice

The effects of obstetric risk practices can be mitigated when trust within the mother-midwife relationship acts as a catalyst for identity work and supports the midwife's role as a risk-negotiator. The achievement of mutual identity-work through the midwives' role as risk-negotiator can contribute to improved outcomes for women receiving continuity of care. However, midwives needed to perform the role of risk-negotiator while simultaneously negotiating their professional credibility in a setting that construed their practice as risky.

Introduction

The term continuity of care has been defined in a variety of ways (Hatem et al 2008; Sandall et al 2013) and for the purposes of this study was defined as a midwife with responsibility for providing antenatal, intrapartum and postnatal care to the women in her caseload and sharing these responsibilities with medical colleagues for women at higher risk. Literature over the last fifteen years documents the effectiveness and safety of midwifery continuity of care and demonstrates women's preference for such care (Homer et al 2002; Tracy et al 2005; McCourt et al 2006; Hatem et al 2008; Henderson, Hornbuckle & Doherty 2007; Turnbull et al 2009; Fereday et al 2009; Improving Maternity Services in Australia 2009; Sandall et al 2013). A recent randomised controlled trial of midwifery caseload versus standard maternity care for 2,314 low-risk women in Australia (McLachlan et al 2012) has further confirmed that continuity of care can significantly reduce intervention in birth, particularly caesarean section, and improve outcomes for babies while maintaining safety. However, despite research findings supported by numerous federal and state government reviews, evidence for the safety and suitability of primary midwifery care for low risk women has not yet resulted in major change in Australia. Currently less than 10% of Australian women are able to access primary care from a midwife (Laws, Li & Sullivan 2010).

Much of this lack of reform has been attributed to the effects of childbirth risk reconceptualisations over the last century (Murphy-Lawless 1998); effects which continue to dominate today (MacKenzie Bryers & van Teijlingen 2010). Medicalisation of childbirth was supported by the accumulation of mass statistical data on individuals and quickly became estimates of risk applicable to whole populations (Lupton 1999). When subsequently re-applied to childbearing women, risks were not only factual entities able to determine the likelihood of danger but were embodied in outcomes for which women were increasingly responsible. Lupton (1999 p 66) argues this resulted in the assumption that if childbearing women know about their risks, they will (and should) take precautions to avoid them. Such assumptions have shaped maternity services policy worldwide and, despite being safer than ever in the developed west, birth is an event for which risks must be identified, calculated and managed (Lane 2006; Tracy 2006).

Edwards and Murphy-Lawless (2006) argue that medical control of childbirth was inevitable once doctors offered guarantees of safety, and such assurances remain the foundation on which medical dominance of childbirth rests (Skinner 2003; Symon 2006; Reiger 2006; MacKenzie Bryers & van Teijlingen 2010). As Tracy (2006 p. 232) acknowledges, medical assurances countering the 'inevitability of risk' in childbirth were a compelling directive for women, a directive Dahlen (2010) argues is now conflated with an unwarranted emphasis on catastrophic adverse events in childbirth. Such events, though relatively uncommon in the west, have nevertheless become powerful determinants of care provision (Dahlen 2010) and have significantly affected women's outcomes (Stahl & Hundley 2003; Redshaw et al 2007; Fahy 2011). The most recent figures from 2008 show just 36.9% of women in Australia gave birth according to a definition of 'normal' which excludes induction, augmentation, instrumental birth, spinal, general or epidural anaesthesia (Laws, Li & Sullivan 2010). Increasing intervention brings additional risks to mother and baby from a rising caesarean section rate (Gilliam, Rosenberg & Davis 2002; Souza et al 2010) and its well-documented psychosocial sequelae (Parratt 2002; Beech & Phipps 2004).

Western childbirth practices that recruit women into high levels of risk self-surveillance also result in high levels of fear (Reiger, Possamai-Inesedy & Lane 2006). A study by Fisher, Hauck and Fenwick (2006) shows that women fear the prospect of a medical event over which they will have no control, and Nilsson and Lundgren (2009 p. e7) have demonstrated links between negative birth experiences and high levels of fear in subsequent pregnancies. Dahlen (2010) considers an increased fear of childbirth to also be a strong influence on midwives' clinical practice, determining the type of care they are willing to provide. Edwards and Murphy-Lawless (2006 p. 45) found many midwives practiced within the 'narrow parameter of risk management' which curbed their ability to provide individualised care, or to support women's choices. Similarly, a study by O'Connell and Downe (2009 p. 590) indicates that while many midwives continue to speak of a commitment to 'real midwifery', they practice 'in hierarchical, rule-governed hospital settings' that they feel powerless to change.

Ironically, the effectiveness of women's and midwives' opposition has been weakened by the consequences of legal interpretations of medical guarantees offered to women. When the

inevitable ensued and the perfect baby could not be delivered (Wilson & Symon 2002) recourse to the courts has seen an escalation in litigation that has become a central driver of obstetric practice in Australia and other western countries (Clark et al 2008). Major increases in litigation settlements has driven exponential growth in premiums for Professional Indemnity Insurance and medical fears of an adverse birth outcome have intensified (Chandrabaran & Arulkumaran 2006; Seymour 2010), leading to further over servicing of normal birth (Albers 2005). Consequently, greater surveillance of low-risk women for medico-legal reasons has fuelled a rise in defensive practice in obstetrics (Mann 2004; Williams & Arulkumaran 2004; Fuglenes, Øian & Kristiansen 2009) and led to growing concerns about the effects of litigation on the obstetric professions' future (MacLennan et al 2005; Hankins et al 2006; Bismark & Paterson 2006).

Unfortunately, such outcomes have not resulted in doctors' accepting greater responsibility for excessively negative perceptions of the riskiness of childbirth or for increased levels of fear. Calls for a more balanced view of childbirth risk do not appear to be gaining traction either (Weaver, Clark & Vernon 2005; Reiger & Dempsey 2006; Skinner 2011; Dahlen 2012a), and the outcome is a birth culture where, on the basis of risk, primary midwifery care is deemed a 'luxury' unsuitable for most women (AMA 2008 p. 11) and a woman's birth 'experience' is pejoratively judged as secondary to ensuring the safety of her baby (De Costa & Robson 2004 p. 438). New Zealand, with a twenty year history of midwives working with greater autonomy, has provided valuable insight into how midwives challenge (or work around) medical conceptualisation of childbirth risk, and yet recent studies suggest midwives there still grapple with the effect of these medico-legal constraints. In accounting for this, Skinner and Foureur (2010 p. 34) suggest medico-legal concerns remain the primary driver for intervention in birth, and contrasting viewpoints between midwives and doctors still persist to such a degree that they remain 'the central challenge to collaboration' between the professions.

Midwives' and women's concerns have not gone unheeded, however, and in late 2010 Medicare¹ funding was extended to a new classification of midwife for the provision of primary maternity care - the eligible midwife - and a growing number of midwives are seeking the

¹ Australia's universal health care program, funded by a levy paid through the taxation system.

required accreditation (Nursing and Midwifery Board of Australia (NMBA) 2010). Ongoing medical opposition (Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) 2008) has led to the inclusion of contentious and restrictive eligibility criteria for collaborative arrangements with 'a named doctor' in order to access Medicare funding (Lane 2011), although attempts have been made to change this to the more generic 'health care provider', following doctors' reluctance to engage with midwives outside traditional hospital-based roles. Should attempts to loosen the eligibility criteria succeed, they represent an important step in reducing the medical monopoly on primary maternity care provision, and encouraging midwives in Australia to move into more self-determining roles (Dahlen 2012b).

Despite the increasing focus on risk in maternity care there is little understanding of how midwives and the women they care for conceptualise risk and safety within the context of primary midwifery care. This study was undertaken (as a doctoral thesis) with the aim of examining how midwives and women within a continuity of care midwifery program in Australia conceptualised childbirth risk and safety, and the influences of these conceptualisations on women's choices and midwives' practice.

Methodology

Ethnography was chosen for its historical and functional concern with the study of human culture, as observed through patterns of language, communication and behaviour, as well as for its ability to focus research attention on the lived context of participants' lives (Atkinson et al 2001). In addition, because the aim of the study was to examine how childbirth risk and safety were conceptualised by participants, and the influences of these conceptualisations on women's birthing care choices and midwives' practice, a critical approach to ethnography (Carspecken 1996, 1999) was chosen as this provides two additional strengths. First, it is a framework that acknowledges cultural impacts on practice as dynamic processes rather than fixed entities. Second, an orientation based on Habermasian critical social theory emphasises the emancipatory intent of the research endeavour (Habermas 1984; 1987). Critical approaches allow for a view of culture as 'a contested process of meaning-making' whereby actors take the 'implicit practices and rules...and...challenge, stretch or reinterpret [them]' (Wright 1998 p. 9).

Not only does this approach expose relations of power in the production of culture, it also shows how complex interactions between people result in recognisable patterns of language, communication and behaviours that produce and reproduce such power relationships. To recognise these patterns as they occur in practice requires an extended observation time, in addition to a methodology attentive to examining the meaning people make of these patterns in a particular time and place and how they position themselves in response to them.

Data collection and analysis

The continuity of care midwifery program in this study is located within a Community Health Centre and is managed by the Centre Manager (the researcher (SD) had acted in that role several years earlier). The midwives have clinical privileges at the local hospital and can book women there for birth as well as offering a home birth option. The midwives each carry a caseload depending on their workload, with another midwife acting in a 'back-up' role to cover leave and days off. Women of all risk categories can attend for care and in the case of higher risk women, care is shared with hospital obstetricians. The practice of the program is also to prioritise the admission of women who meet one of a number of risk categories, including aged less than 18 years, low socio-economic status, women of Aboriginal descent and women from culturally and linguistically diverse backgrounds.

Ethics approval was obtained from the University Human Research Ethics Committee, with subsequent permission for a critical ethnography granted by the Community Health Service employing the midwives. All eight program midwives and two medical officers associated with the program were sent recruitment letters and information sheets. Signed consent was obtained from the eight midwives and one of the medical officers, an obstetrician working in the local hospital. The obstetrician provided clinical support to the program and was included in the study for the insight provided into the way the midwives conceptualised risk and safety, rather than for the way in which this doctor viewed these concepts. The second medical officer, who worked more generally in women's health in the Centre, resigned just as data collection began and was therefore not included.

The midwives then provided written information to women in their care, requiring women to contact the researcher directly if they wished to participate, thus avoiding the potential for women to feel compelled to comply with their midwife's request. Seventeen women contacted the researcher, with nine opting for an hour-long face-to-face interview and a further eight women choosing to allow sequential observation of their antenatal clinic appointments. It was felt that the ability to listen to and observe discussions concerning care choices and clinical decision-making would provide the richest source of data to address the research question, and five women were observed on two occasions and three women observed on three occasions. Five of the midwives were interviewed twice, three were interviewed once and the Obstetrician once, with consent confirmed again verbally on the commencement of each interview or observation of an antenatal appointment.

The fieldwork occurred over nine months and approximately twenty hours per week were spent in the field. This involved observation of Health Centre activities involving the midwives, for example in their office area and antenatal clinic appointments, and in undertaking one-to-one semi-structured interviews. Fieldwork also included 'shadowing' the program's activities outside of the Health Centre by accompanying midwives and observing meetings within the hospital or within the community, including in their role as educators within community groups. All interview and antenatal visit observations were audiotaped and transcribed, and transcripts were returned for review and comment.

Data were collected utilising Carspecken's (1996 pp. 40-43) 5-stage Framework designed to elicit cultural meanings operating within the field of study. In stage one the 'primary record' was compiled: a written record of initial observations and interaction in the site that is monological in that it was limited to the voice of the researcher, using language with as little inference as possible and observed in a range of practice contexts in order to map the 'validity claims' (claims to truth) made by participants (Carspecken 1996 pp. 55-57). Peer debriefing with participants was regularly used for evidence of researcher bias or inferences in documented statements made by participants in the field. In stage two ('Preliminary Reconstructive Analysis') the primary record was used to develop possibilities for 'reconstructions' represented in the patterns of interaction, power relationships, interactive sequences and the roles of those

being observed (Carspecken 1996 p. 42). This occurred on site and in other 'locales' (such as the hospital) that either impacted on the site or represented locations where the midwives sought to have an influence. Clear differentiation between observer's comments and participants' words was maintained and 'member checks' involved sharing the researcher's understanding of participants' meanings with them. Stage three involved a process of dialogical data generation aimed at 'democratising' (Carspecken 1996 p. 42) the research process, whereby participants engaged in interviews, group discussions and focused conversations. This stage deepened and contextualised the information gathered in stage one and also corroborated (or contradicted) early reconstructions from stage two. Data analysis began and continued throughout the remaining stages.

A process of continuous normative reflection examined where any biases and cultural assumptions of the researcher might be operating and transcripts were returned to participants for review and comment. In stage four the emphasis was on clear connections between the data and the findings they supported but with increasing inference. This stage also involves identifying where 'cultural forms' used by participants occur across sites, to help determine the operation of cultural themes (Carspecken 1996 p. 200). Finally, in stage five the system relations generated in stage four were used as an explanation of findings with reference to broad system features and to social theory. Claims to methodological rigour within Carspecken's framework are based on the detailed validity requirements outlined for the data gathered in each stage and should be subjected to member checking (with participants) and regular discussion with peers (Carspecken 1996 p. 141). However, as the study was undertaken for a doctoral thesis, it was necessarily constrained by being limited to one researcher to collect and analyse the data (SD), and regular meetings to discuss emerging findings with a supervisor (EM-C).

Findings

Three major categories and three sub-categories were developed from the study data. This paper focuses on the categories that best exemplify the conceptualisations of childbirth risk and safety demonstrated within the culture of the program, namely identity work and risking

normality² (which includes the three sub-categories of protecting (keeping it normal); preparing (reinforcing normality) and preventing (resisting risk)) (See Table 1 for category and sub-category relationships). Pseudonyms for participants have been used throughout the findings section of the paper.

[Table 1]

Identity Work

Recognition of the midwives' role as risk-negotiator developed out of an analysis of identity claims made during interactions between midwives and women and involved reciprocal attempts by the midwives and the women to identify and position themselves as safe within an obstetric risk discourse. The category of identity work was defined as *the processes through which the mother-midwife relationship facilitates the active and collaborative construction of identities as 'safe mothers' and 'safe practitioners' in response to mainstream perceptions of riskiness*. This involved both the making of identity claims and the subsequent negotiation of identity, with midwives acting as risk-negotiator during interactions involving identity work.

The catalyst for identity work was the trust engendered by a 'continuity relationship' (that is, the relationship between the woman and the midwife which develops over the course of primary care) and trust was considered by the midwives to be central to their understanding and management of childbirth risk. Trust in the relationship was also central to women's sense of safety. References to trust within the interactions occurred most frequently when discussing in the antenatal period situations where intervention might be needed, or decisions regarding birthing choices were required:

...with the relationship that you get with the woman...if you say 'Look, I think we need to do this' they know... that something needs to be done...[that] I'm only going to call somebody else into the room if things aren't going along like they should be. So you have that rapport with them and they feel safe in that process. (Interview with Vicki, Midwife)

² The study also identified the category *enabling embodiment*, related to a woman's bodily experience of pregnancy and birth.

...if I am starting to have doubts, she's having them already anyway. So quite often they already know that it doesn't feel right. Even if it's a first baby a woman knows that something is not quite right. It only takes me to say two words and they say 'Yeah, I was already feeling that, okay, let's go'. (Interview with Tracey, Midwife)

The trust generated by the continuity relationship was also closely linked to the facilitation of a woman's sense of identity as an individual, rather than as just another patient:

That's what the continuity is about isn't it? So they get to know you and you don't have to keep saying who you are and what you would like, but also it means that they remember things so it's really...important. (Interview with Isabella, woman)

Women also spoke of developing a sense of empowerment through the relationship, which they linked with feeling in control, for themselves and their birth:

I just love the other support you get as well...I feel a lot more in control of my pregnancy and in control of my body and then when I was giving birth I was in control of everything that went on. (Interview with Leanne, woman)

The following exemplar is representative of numerous identity negotiations embedded in risk-related interactions between the women and the midwives:

Georgina: Yeah, I said to her [friend] 'You know, I've always had all these drug free births and then...right in the last minute I get a jab in the leg'. I said 'Mmm, I might not do it this time' and she went to me, she said 'What?! That's silly. What if you start haemorrhaging?' but I'm like 'Nah, I don't think...I don't think I want it.'

Midwife: No, well you don't have to have it.

Georgina: Oh good! And she said 'Speak to your midwife' and I said 'I'm going to.' She was having a bit of a heart attack about it...

(Georgina's antenatal visit with Yvonne, Midwife)

Among the identity claims made by Georgina is that she births well (*I've always had these drug free births*) and is capable of making decisions concerning her birth (*Mmm, I might not do it this time*), yet she is also aware of the possibility that the midwife might share her friend's safety concerns. Consequently, she recounts the conversation from a number of perspectives, or positions, including her own perspective (first-person), the midwife's perspective (second-person), and from the perspective of her critical friend (third-person), to effectively sound out her midwife (Carspecken 1996 p. 99). Together they negotiate the 'possible meanings' implicit

in the retelling of the previous interaction (Carspecken 1996 p. 79) and a 'shared meaning' concerning the safety of physiological third stage is established:

Midwife: So do you know the process behind it [third stage]?

Georgina: A little bit, I think...

Midwife [provides detailed descriptions of physiological and managed third stage]...but we have no indication whatsoever to say that you need that.

Georgina: Oh good.

Midwife: I mean, like, you've never had a problem with it, never had bleeding...

Georgina: No.

Midwife: You know if you had had bleeding after a birth or if you'd had intervention...then you might have needed it [an oxytocic] but you haven't needed any of those things, so, no.

(Georgina's antenatal visit with Yvonne, Midwife)

The creation of safe identities was achieved through considerable repetition in similar interaction. This included the telling and re-telling of birth stories, often with the same birth stories discussed over several visits as a means of identifying and sharing their knowledge of the women's desires for birth in the current pregnancy. This use of storytelling was also central to the practice of contextualising *individual* risk by grounding a woman's risk in her experience, past and present, rather than simply assigning a generalised risk status as determined by population data. In this exemplar, Georgina's sense of her ability to do as she desired was reinforced when, together with her midwife, they established and maintained her identity as a safe mother who births well. For the midwife, her identity claim as a safe practitioner was reinforced by focusing on Georgina's history and recounting her knowledge of precautions that she would take in the event of a problem, rather than on the warnings of imminent haemorrhage (and by implication, death) that Georgina's friend was using to dissuade her. For Carspecken (1996 p. 79), such identity claims are an expression of culture, which is reinforced when mutual acts of identity formation result in a shared meaning. Efforts to reinforce safe identities (and thus expressions of culture) were also evident in a discussion regarding third stage with a woman who had experienced heavy post-partum bleeding:

Ellie: I think this time we'll wait until after the placenta's detached and everything and then just do it [oxytocic injection] straight away, to...just avoid the hassle.

Midwife: Oh, okay. I knew that you wanted everything to be completely natural during your labour, but we hadn't recorded anything about third

stage so, that's what I wanted to check...whether you wanted to still try and do it naturally this time or whether you wanted to...

Ellie: No. As soon as the placenta's detached, I'll do it.

Midwife: Okay, so...wait till the cord stops pulsating then cut the cord and then give you the injection?

Ellie: Yep!

Midwife: That works. I'll make a note of that.

(Ellie's antenatal visit with Wendy, Midwife)

A physiological third stage is deemed risky by most doctors, especially so when a woman has a history of post-partum bleeding. These negotiations illustrate the many mutual processes of reciprocal recognition and acknowledgment that occurred between midwives and women in their attempts to establish and maintain their identities as safe within a context of childbirth as risk-saturated. They also demonstrate the midwife's role as a risk-negotiator within these encounters, as opposed to a health practitioner who might determine, rather than negotiate, risk.

Risking normality

Closely linked to identity work was the category of risking normality, defined as *the midwives' willingness to risk censure in providing care they believe to be safe and effective in ensuring women have the best chance of the birth they desire*. It is essential to see the following subcategories as arising out of the relational experience and dependent upon identity work for success. Risk in the program context was effectively reconceptualised in an effort to shift the focus from *risks to* a woman and her baby as a consequence of childbirth, to *risks from* a system that the midwives believed could compromise a woman's opportunity to birth normally. The work involved in achieving this is encapsulated in the following three subcategories, the first two of which occurred primarily at the site during antenatal care and the third primarily within the hospital setting during birth care.

Protecting (keeping it normal)

The first sub-category of risking normality arose out of the midwives' responses to the medicalisation of birth where protecting (keeping it normal) was defined as *protecting women from the risks of the blanket application of practice protocols by working to assert that pregnancy and birth are normal life events*. As illustrated in the previous excerpts, where

women's care choices contested standardised approaches to labour and birth and lacked an evidence base, midwives and women worked together to enable the desired outcome:

Bernadette: (in a whisper) I think I was snuck on the other side [the low-risk side of the labour ward] (laughter)

Midwife: Oh, that's right!

Bernadette: Because I wasn't supposed to be there, cause it was natural [birth] after Caesar.

Midwife: Yeah...

Bernadette: And they [hospital staff] are like 'Oh, you can't go over this side for that!!' but you're like 'Oh stuff them, we'll do it.'

(Bernadette's antenatal visit with Sarah, Midwife)

In a later conversation to clarify the exchange, the midwife stated:

If we'd gone straight by the guidelines we wouldn't have been in the birthing unit [low-risk side], but I think we were practising safely, we were giving the woman choice, and we didn't interfere... (Field note of conversation with Sarah, Midwife)

In a later consultation between the two:

Midwife: And then we went a full 9 days over with [son]? Did we have any hassles? Doing that?

Bernadette: Umm... we broke my waters and nothing happened. I went for a walk first...and then once you put the drip in...he was out in blooming three and a half hours! (Bernadette's antenatal visit with Sarah, Midwife)

On later questioning the midwife about her meaning with this question, she confirmed she was asking if they had any 'hassles' with the hospital doctors for going so far into her last pregnancy. In asking this, the midwife was effectively calculating the degree of medical opposition she was likely to encounter and planning how to achieve what Bernadette desired for her birth. This excerpt is also an example of the use of storytelling to create safe identities and a culture of safety, as these same stories were repeated in each of the three visits observed.

Preparing (reinforcing normality)

From the midwives' perspective, the arbitrary labelling of risk was not just the domain of hospital staff. Uncertainty also characterised women's understandings of risk and the midwives attributed this ambivalence to culturally entrenched perceptions of risk that could result in women defining normality in narrow terms that interfered with normal birth. Consequently, the second sub category of risking normality was a process of preparing (reinforcing normality),

defined as *preparing women for the hospital system by identifying her desires for birth, reinforcing her confidence in their shared knowledge and negotiating decision-making about care choices*, as illustrated here:

Midwife: So, what is the plan for birth? You're going to go into labour yourself, isn't that right?

Bernadette: Yeah, maybe...hopefully! (laughter)

Midwife: Great! And we had the long conversation last time too, that your best chance of having a normal vaginal birth after caesarean is by going into labour yourself. When you didn't do that, you had the induction, but..

Bernadette: It still worked!

Midwife: It still worked and it's fantastic because it'll probably...it gives you a greater chance of having another vaginal birth after caesarean too. It's a case of if we can avoid [induction]...

(Bernadette's antenatal visit with Sarah, Midwife)

The midwives believed that, at times, women's view of high-risk pregnancy care being the exclusive domain of obstetricians meant that the benefits of continuity became lost in the face of their anxiety. Consequently, in addition to directly attempting to address deeply entrenched notions of risk, these processes of reinforcing normality were at times tacit, as they relied on the midwife's ability to reinforce for the woman what they knew to be normal:

So there's this woman – she's just met this doctor for the first time - and he tells her "Your baby is at risk of dying" What are you [the woman] going to do?

Interviewer: And what's it like for you in that situation?

Very difficult...so what you do in that situation is try to counter balance [the threat] by saying that all your investigations have been normal and everything is well, the baby is active and tell them that it's their right to make a choice and a decision about it, but it is very powerful.

(Interview with Ruth, Midwife)

The development of relationships and the ensuing ability to contextualise individual risk also enabled the midwives to pick up on many of the social issues which impacted on women and which may not otherwise be recognised as placing women at risk. Examples include a woman's fear of birthing with a dozen strangers in the room, as occurred in a previous birth; of not wanting to let staff know about the paternity of a child, or being afraid her bowels will open in labour. Through discussion and individualised care, they were able to confirm what is normal in labour, reduce fears and mitigate risk.

Preventing (resisting risk)

The third subcategory occurred most frequently within the hospital setting, being in effect the operationalisation of the identity work initiated through the mother-midwife relationship. It was defined as *preventing attempts by medical discourses of risk to judge mothers'/midwives' knowledge as inferior by challenging pressure to conform to non-evidence based protocols and resisting system constraints on women's choices*. Conflict most often arose over time-centered assessments of risk (post-dates and labouring for longer than prescribed time frames) where hospital-based midwives and doctors were concerned with strictly implementing guidelines. This was particularly the case where women of low risk, and without valid indicators, were subject to the application of protocols designed for high risk, or at-risk women. The following exemplars highlight the relational context for the use of resistance by the midwives:

A...woman was pushing for quite a long time but everything was fine, baby was normal and the woman wanted to go on...but...a [hospital] midwife...didn't want them to go on... it was very, very tense for myself and the other program midwife because we had midwives very on edge outside. (Interview with Vicki, Midwife)

...in labour the heart rate dropped ... I knew she was in second stage and that it was just head compression dips [but] the doctor...wanted all this intervention and she turned to me and said "Should I do that?" So just being with her and knowing her meant that 10 minutes later baby was born...so just knowing her and knowing her huge fear [of strangers in the room] I had no qualms in telling the doctor "I will come and get you if I think there is a problem". (Interview with Tracey, Midwife)

Here, a midwife discusses how her initial lack of experience led to compliance with policies that could increase a woman's chances of intervention in birth, whereas a more experienced midwife considers time limits on pushing to be more of a guide:

Because the [hospital] protocol says 'one hour in second stage' type thing, when the doctors ask Sarah, she'll go 'No, she's in transition' which [really] means she's starting to push but she'll [Sarah] know that it's a first time pregnancy and she [the woman] isn't pushing properly so she'll let her have that time. Whereas [at first] I'd be going 'Oh yes, we have started to push' do you know what I mean? (Interview with Zoe, Midwife)

Another midwife discussed a woman attempting a vaginal birth after caesarean (VBAC) whose decision to decline protocol (nil by mouth, intravenous cannulation and continuous Cardiotocography (CTG)) had been supported and documented by her obstetrician:

They [Obstetric registrar on-call] asked her to sign an 'at risk' form when [the] head was on view and she's there signing a form to say 'I'm going to have a natural birth'. It kept everyone happy...but it did escalate her pain. I could see it when they started badgering her... (Interview with Terri, Midwife)

As all was going well for the woman, this midwife called in a colleague to manage the interruptions from staff who considered the woman at risk (and thus her care to be 'risky'); she was willing to risk censure to provide care she believes to be safe and more likely to result in the woman achieving her desired birth. The midwives identified this wrestle for control as being driven by a medical fear of litigation rather than a concern over safety, stating that once the 'at-risk' form (a risk waiver) was signed the doctors were satisfied. This fear of litigation appeared to narrow the margins of safety allowable to women and potentially limit their choices, as voiced by the obstetrician:

The way we have to practise now is...to try and predict if, or foresee the bad outcome, and... minimise it. Sometimes [this is] to the detriment of the choice of the woman because if it comes out alright well, then you say "Well fine, we probably didn't need to do it" but if it turns out to be bad then you have to unfortunately be able to show that we did, to the best of our ability, everything we possibly could to limit this problem happening, or we haven't got a leg to stand on [legally]. (Interview with Dianna, Obstetrician).

A field note made at the time also reflects the midwives' concern over what they called doctors' 'blanket approach' to determining risk and responding to risk parameters, rather than assessing risk on an individual basis:

On the low risk side [of the labour ward] the midwives are generally left alone whereas on the high side they will regularly see the obstetric team whether they request a review or not and despite a woman's progress. Their assurances to staff that 'all is well' carry far less weight in that domain. Instead they refer to a 'blanket approach' where doctors expect guidelines to be rigidly enforced. (Field note)

The midwives also spoke of their efforts to develop relationships of trust with hospital doctors that they felt could support women's decision making and prevent risk:

So again...building that trust, working with them [doctors] a few times and getting to know them...and when they say things like 'This woman is high risk,

she can't come to you' you say 'There are other things that we deal with rather than just measuring the woman's belly'. (Interview with Yvonne, Midwife)

So it is about negotiating [with the doctors] those visits [with high risk women] then [saying] ' So if you see them this visit, should she see the midwife next visit?' etc. It just takes time...well it has taken time to develop that trust between us. (Interview with Sarah, Midwife)

On occasion, hospital staff failed to inform the midwife when a woman was admitted in labour. While this only occurred if women were unable to contact a midwife directly, it had a significant impact on several women's experiences:

They [hospital midwives] wouldn't ring them for me. The excuse was 'Oh, you could go on forever'...but I said 'But I have no one here!' They didn't ring...so I had no support, nothing... I wanted someone to support me through it... (Interview with Janet, woman)

She's gone into labour at 3 am but they [hospital midwives] hadn't bothered to page, you know, as they do. When I arrived they're like 'Oh, we're getting an epidural into her, she's only 3 cm [dilated] and she's...hysterical in there'. In the room, she was...'Oh...I've been waiting for you...I can't do this! I can't do it!'...'Yes, you can do it!' She birthed at half past 10 - do you know what I mean? (Interview with Zoe, Midwife)

The comment 'you know, as they do' referenced other examples of reluctance to contact program midwives or their exclusion from consultation about a woman's care once she was admitted to hospital. In the case of a woman with chronic but idiopathic abdominal pain, it resulted in an unnecessary caesarean section:

I got there [and] they'd already arranged a section...she was all prepped because of this pain which seemed to me to be...normal and not out of the ordinary [for her], but they thought 'Oh, abruption! Abruption!' And there was no sign of abruption, of course, at section .(Interview with Tracey, Midwife)

Thus the categories of identity work and risking normality, achieved through the sub-categories of protecting, preparing and preventing reflect the core components of the midwives' role as risk-negotiators. By resisting pressure in their clinical decision-making to conform to the blanket application of guidelines that were often not evidence-based (and which they considered jeopardised women's desired outcomes) they successfully resisted system constraints on women's choices. As a consequence the women within the program, despite being from social groups who traditionally experience greater levels of intervention, experienced lower rates of

induction, epidural anaesthesia, episiotomy and caesarean section and higher rates of vaginal birth, compared to the State average.³

Discussion

This study identified that relational identity work enabled the midwives to undertake the role of risk negotiator and, in mitigating the impact of obstetric risk practices not based in evidence, facilitate care that contributed to more women achieving their desired birthing outcomes. The findings highlight a number of issues regarding the importance of the mother-midwife relationship as a catalyst for the role of the midwife as risk negotiator within the context of continuity of midwifery care, discussed below.

Relationship as catalyst

The findings underline the importance of the relationship between the midwives and the women for the success of the continuity of care program. This is consistent with a great deal of literature on this crucial bond (Guilliland & Pairman 1995; Walsh 1999; Kirkham 2000, 2003; Kennedy & Shannon 2004; Hunter 2006; Lundgren & Berg, 2007; Homer, Brodie & Leap 2008). More recently, McLachlan et al's (2012) study confirming the benefits of continuity of care acknowledged the likely significance of the mother-midwife relationship to outcomes but, importantly, noted the lack of evidence concerning just which characteristics of continuity resulted in improvements. While they have proposed midwives' self-selection into the care model as a possible explanation (with its assumption that a philosophical commitment to normal birth will translate into practice that supports it) few studies have looked at specific relationship characteristics as drivers of outcomes (McLachlan et al 2012 p 8). This is not to suggest a simplistic causal connection between the relationship and women's outcomes for as Hunter et al (2008) point out, the complexity of the mother-midwife relationship and its interplay with maternity care systems makes any simple inferences impossible. However, the lack of evidence concerning how continuity results in improvements is compounded by an historical reliance on interviews and surveys to elicit midwives' philosophical beliefs and commitment to the mother-midwife relationship (Hollins-Martin & Bull 2005, 2006; Edwards &

³ The limited number of women in the program precludes any comparative statistical analysis of the data.

Murphy-Lawless 2006) rather than observational methods to determine if attitudes translate into practice (Freeman et al 2006). In utilising direct observation of practice to determine how midwives and women negotiated risk, this study identified not only the centrality of the relationship but also its role as a catalyst for identity formation through mutual identity work. Consequently, the findings suggest that, rather than the possession of particular attitudes (Scammell 2011; McLaughlin et al 2012) outcomes are related to the midwife's philosophical position being operationalised as a result of her relationship with a woman.

Identity work processes within the site

Identity formation emerged as an active process in this study. Identities as safe mothers and practitioners developed out of intersubjective processes within their relationship, such as that illustrated by Georgina's position-taking in relation to her choice of a physiological third stage of labour. The study presented here adopted Sveningsson and Alvesson's (2003 p. 1165) definition of identity formation as it depicts the creative elements in the work undertaken by women and midwives, namely 'being engaged in forming, repairing, maintaining, strengthening or revising...constructions that are productive of a sense of coherence and distinctiveness'. Identity formation as an active process has not historically featured in midwifery literature concerning identity, instead this literature has emphasised the role of the individual rather than how wider social and cultural influences, and in particular relationships, shape an identity as a midwife or a mother (Foley & Fairclough 2003). Earle's (2000 p. 237) study of pregnant women suggested an internal process using others as a measure of 'similarity' and 'difference' in relation to oneself, but without an active, relational dimension. King et al (2009 p. 140) also emphasise the individual, which can gloss the possibility that meaning is constructed interpersonally and interactions not only influence, but also fundamentally create, identity.

Dynamic processes of identity formation are also described by Giddens (1991 p. 54), wherein 'self-identity...has to be routinely created and sustained in...reflexive activities...' and one way in which women and midwives in this study created safe identities was through reiterative storytelling. While women have always used birthing stories to debrief past births and to provide a context for their current experiences (Skinner 2010) here the significance of birthing stories was in their contribution to processes of identity work. In addition to the maintenance

and strengthening of identity proposed above by Sveningsson and Alvesson (2003 p. 1165), a link between the stories we tell and identity formation is also asserted by Giddens, where individuals 'continually integrate events which occur in the external world, and sort them into the ongoing 'story' about the self' (Giddens 1991 p. 54).

For Carspecken (1999 p. 96) 'successful acts...strongly invested with the need to construct an identity feel empowering' and consequently, where women and midwives in this study succeeded in creating identities as safe, they reported feeling empowered. Unsurprisingly, a sense of empowerment has been positively associated with women's increased satisfaction with care (Hatem et al 2008; Walsh & Devane 2012; Sandall et al 2013) and improvements in postnatal mental health (Yelland et al 2007).

Identity work processes outside the site

For the midwives in this study, establishing and maintaining identities as safe practitioners was a response to genuine challenges, with the attribution of riskiness imposed on them by some staff in mainstream maternity services being a crucial catalyst for the midwives' risk negotiator role. Where staff in the hospital did not share their conceptualisation of risk, the risking normality subcategories of protecting and preparing that occurred largely outside the hospital in effect laid the groundwork. When differences in risk conceptualisation impacted on their ability to provide care, midwives' drew on their intersubjective identities as safe practitioners to move into preventing (resisting) risk through the risk negotiator role. Part of this effort was to negotiate trusting relationships with doctors that they could then draw on when needed. In this way, in the absence of valid indicators for intervention they could move the focus from blanket risks assessments, which might impact, on a woman, to making choices based on an individual woman's circumstances. Consequently, when conflict arose over practice decisions, the midwives attempted to draw on the trust cultivated in these relationships and negotiate risk by seeking to satisfy the imperatives of policy while keeping within evidence they considered valid. Skinner (2010 p. 75) has called this process of relationship development 'working the system' and in this study it was identified as vital for facilitating women's birthing choices. However, in the midwives' experience, relationships with individual doctors were limited by the systemic impact of medical risk conceptualisations that privileged adherence to policy-driven care

despite whether women were 'at risk' in relation to the policy. Midwives identified difficulties overcoming the fear of the medico-legal implications of poor birth outcomes, which they viewed as a key driver in doctors' need to remain in control of women and their progress in labour (Skinner & Foureur 2010). Evidence for this included doctors' acceptance at times of an 'opt-out' waiver (requiring a woman to assume the risk) with pressure for a change in practice being removed once the waiver was signed. This also suggests that rather than philosophical differences between doctors and midwives over conceptualisations of safety (De Costa & Robson 2004) a culture of defensive obstetric practice due to fear of litigation was contributing to the application of blanket risk assessments (MacLennan et al 2005; Tracy 2006; Clark et al 2008; Skinner & Foureur 2010).

For Carspecken (1996 p. 191) culture is expressed wherever actors draw on 'cultural themes' that others recognise as 'typical' for that group; this may only involve a family or a neighbourhood, but where cultural themes are recognised as typical by many people they spread across sites and locales. As identity is tied to cultural reproduction (Giddens 1991; Carspecken 1996; Sveningsson & Alvesson 2003), then tension between program midwives and doctors in the hospital setting can be viewed as reflecting midwives' relative inability to draw on cultural themes of risk and safety (and the associated identities) that are typical within the program. Within the hospital, and reinforced by the environment in which they work, doctors were well placed to draw on cultural themes, and related identities, concerning the riskiness of birth that are distributed across so many locations they have become society-wide. The power that adheres to widely distributed cultural themes can 'act as a constraint on action' (Carspecken 1996 p. 191) not only because it limited the midwives' access to their cultural themes, but because it limited the doctors and hospital midwives from acting differently; 'one cannot act in ways that would require themes to which the actor has no access' (Carspecken 1996 p. 191). Brodie et al (2008 p. 155) have stressed that midwives working in continuity models require managers who can support them when a woman's informed decision-making 'conflicts with the unit's guidelines for practice'. However, this support was rarely experienced by the midwives in this study, and these findings suggest that, to be effective, managers of continuity models need to share cultural themes that support women's informed decision-

making and midwives' autonomy. In Walsh and Devane's (2012 p 906) study of midwife led care, while systemic conflict between midwives and institutional, policy-driven demands were also identified, the greater autonomy ('agency') afforded in birth unit settings was central to managing these constraints. Similarly, in this study, the midwives attributed their location in the community as contributing to achieving positive outcomes for women, as location away from the hospital during the antenatal care period afforded the midwives greater freedom from medical surveillance of their practice. Once within the hospital however, their claims to safety were more likely to be challenged and imputations of riskiness had greater potential for professional impact, making the ability to reproduce their own culture through the maintenance of safe identities an on-going challenge.

Further evidence of cultural conflict was seen when women, who required access to their midwife to successfully maintain their identity as safe, were without this if hospital staff did not contact her midwife on admission. For Giddens (1991 p. 91) access to these material or authoritative resources are 'the media through which power is exercised' and it not only denied women access to their midwife's risk-negotiator role, but also to the cultural themes tied to the relational identity established to support their choices. The recurrent nature of such acts suggests that patterns of cultural production (and reproduction) were in play (Giddens 1991; Carspecken 1996) and evidence for the significance of continuous support in labour also meant the implications for these women were immense (Hodnett et al 2007).

Schwalbe and Mason-Schrock (1996 p. 115) claim that 'identity making can be understood as part of a process of cultural struggle' and this is consistent with Carspecken (1996 pp. 197-199) who views identity claims as a means of challenging 'relations of power...' (1996 p. 8). Thus, midwives attempted to change the power dynamic through processes of preventing (resisting) risk but varied in their ability to justify their management of women to medical staff and other midwives. At times this reflected fewer years of midwifery experience, but it also reflected the effect of power relations and highlighted why the risk negotiator role was considered crucial to improving outcomes for women in this study.

Conclusion

The risk-negotiator role was central to the midwives' practice within this continuity of care setting and is fundamentally an active role. In this study, a commitment to women's autonomy translated into actions taken by the midwives to wherever possible protect and promote normality and prevent the application of risk assessments driven by medical concerns over vulnerability to medico-legal consequences. This involved challenges to obstetric conceptualisations of risk when the cultural norm was to suppress individual assessment in favour of blanket risk assessments. Recognising how intersubjective identity work occurred through the mother-midwife relationship can provide a key to understanding the ways in which risk and safety are reconceptualised in continuity programs and can guide midwives who are new to providing care in these models. This recognition can also be a key to understanding the improvement in outcomes experienced within this midwifery continuity of care model, whereby women experienced fewer interventions despite being of all obstetric-risk categories and predominantly from high-risk social groups. The mechanism for this improvement lies with midwives' role as risk-negotiators, with mutual identity work underpinning their clinical decision making in collaboration with women. The study also highlights how the threat of medico-legal liability continues to reinforce a culture of defensive obstetric practice (which affects midwives in all spheres of practice) and drives risk-immersed policy within the maternity care system. The dilemma for the profession then is that while midwives with considerable skill in risk-negotiation can ameliorate the effects of risk policy on individual women's outcomes, maternity care systems require cultural reform at a structural level to accommodate broader conceptualisations of risk and safety in childbirth.

While structural reform will take time, identifying where cultural themes are operating, and how they enable or constrain expressions of identity, may also provide productive ground for reframing midwives' relationships with medical staff. By acknowledging the cultural nature of the differences driving tensions, midwives and doctors can work to address the cross-cultural communication barriers that currently make interprofessional collaboration both problematic and crucial.

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Table 1. Category and sub-category relationships

CATEGORIES	DEFINITIONS
<i>Identity Work</i>	<i>the processes through which the mother-midwife relationship facilitates the active and collaborative construction of identities as ‘safe mothers’ and ‘safe practitioners’ in response to mainstream perceptions of riskiness</i>
<i>Risking Normality</i>	<i>The midwives’ willingness to risk censure in providing care they believe to be safe and effective in ensuring women have the best chance of the birth they desire.</i>
Through sub-category Processes of:	
<ul style="list-style-type: none"> • <i>Protecting (keeping it normal)</i> • <i>Preparing (reinforcing normality)</i> • <i>Preventing (resisting risk)</i> 	<p>(by)</p> <p><i>Protecting women from the risks of blanket application of practice protocols by working to assert that pregnancy and birth are normal life events.</i></p> <p>(by)</p> <p><i>Preparing women for the hospital system by identifying her desires for birth, reinforcing her confidence in their shared knowledge and negotiating decision-making about care choices.</i></p> <p>(by)</p> <p><i>Preventing attempts by medical discourses of risk to judge mothers’/midwives’ knowledge as inferior by challenging pressure to conform to protocols and resisting system constraints on women’s choices.</i></p>