

An Ethnography of Independent Midwifery in Ireland

A thesis presented to the University of Dublin, Trinity College
for the degree of Doctor of Philosophy in Midwifery

By

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DECLARATION

This thesis has not been submitted as an exercise for a degree at any other university and the work herein represents the sole work of the author unless otherwise acknowledged.

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Signed:

Colm OBoyle

Dedication

W Damian Wedge

My Love, my dove, my fair one

Caelum Gill Irwin-Gowran

My delight

Cathal and Norah OBaoill

My pattern and my foundation

Sabine, Colm, Phoebe, Sebastian, Finn, Peter,
Matilda, Teaghan, Freya, John, Eimear, Zoltan,
Daisy, Éanna, Tomás, Eli, Aoife Gisela, and Gus.

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Glossary of abbreviations

ABA	An Bord Altranais (The Irish Nursing [sic] Board)	LHO	(HSE) Local Health Office / Officer
AIMS	Association for Improvement in Maternity Services	LMP	Last Menstrual period
AMP	Advanced Midwife Practitioner	MAI	Midwives Association of Ireland
ANP	Advanced Nurse Practitioner	MICS	Mother and Infant Care Scheme
ARM	Association of Radical Midwives	MOU	memorandum of understanding (between HSE and independent midwives)
CEO	Chief Executive Officer	NCNM	National Council for the professional development of Nursing and Midwifery
CIS	Clinical Indemnity Scheme (operated by the SCA)	NHS	National Health Service (UK)
CMA	Community Midwives Association	NICE	National Institute for (Health and) Clinical Excellence
CMS	Clinical Midwifery Specialist	NMPDU	Nursing and Midwifery Professional Development Units
CNS	Clinical Nurse Specialist	NPRS	Neonatal Perinatal Reporting System (part of ESRI)
DBG	Domiciliary Birth Group	PCCC	Primary Continuing and Community Care
DBIG	Domiciliary Birth Implementation Group	PCT	Primary Care Trust
DoH&C	Department of Health and Children	PHN	Public Health Nurse
DOMINO	Domiciliary In and Out	PPH	Post partum Haemorrhage
DPHN	Director of Public Health Nursing	RCGP	Royal College of General Practitioners
EAG	Expert Advisory Group	RCM	Royal College of Midwives (UK)
EDD/EDC	Estimated date of delivery / confinement	RCOG	Royal College of Obstetricians and Gynaecologists
ESRI	Economic and Social Research Institute	RCSI	Royal College of Surgeons of Ireland
ETH	Early Transfer Home (scheme)	SCA	State Claims Agency
FTP	Fitness to practice hearing by ABA	SECM	Self-employed Community Midwife
GP	General Practitioner	TCD	Trinity College Dublin
HBA	Home Birth Association (Ireland)	VHI	Voluntary Health Insurance (company)
HRB	Health Research Board		
HSE	Health Service Executive		
ICM	International Confederation of Midwives		
IMO	Irish Medical Organisation		
INO	Irish Nurses Organisation		

Prologue

Why would I choose to do home births?

‘There is no cure for life and death, save to enjoy the interval.’
(George Santayana 1863-1952)

Reproduction is common to all living things, but human birth is, unsurprisingly, uniquely special to human beings. Humans are self aware and social beings and so birth is given meaning by us. Birthing is socially situated and its meaning(s) socially constructed. If we take human birthing, like mammalian birthing, to be broadly similar for all pregnancies and births, then it is the social setting and the individual meanings ascribed to birth that help us differentiate one birth, one pregnancy, one offspring, from any other. Our biological similarity or commonality, is overlain with our genetic and social uniqueness. Our births and our birthing have special meaning to us.

I am unique and I am social. I have a unique perspective; I interpret, construct and influence the world around me. My social self however, my self aware ‘I’, is also socially constructed. We do not emerge from the womb as self-aware individuals. Our sense of self develops from our relationship to others, and with others. The context of where and how we are conceived, born and reared, is central to who we are. Birth and birthing, the processes of being made and making humans, are each unique and socially embedded.

I was born but I will never give birth. Neither is unique. I am a midwife and so have attended and assisted at some births. I have worked in maternity hospitals and I have been at births in women’s homes. I support home birth, not least because of my experience of hospital birth. Again none of this is unique, even in Ireland, where over 99.5% of births are planned to happen in hospital. I have spoken with most of the midwives who provide for most of the home births in Ireland today. This is my story, my version, my interpretation of that shared experience. It is therefore, like birthing, both unique and yet socially situated. This story, this ethnography, like any other, is both socially constructed and socially constructing.

In this prologue I want to describe what it is like to be present at a birth. I want, by doing so, to set the scene for the rest of this ethnography. I want to demonstrate what I cannot explain, which is, why I would want to be a home birth midwife, a midwife to a woman birthing at home.

I am a naturalist. I find the metamorphosis of frog spawn from full stops, to commas, then into tadpoles and tiny froglets, absolutely fascinating. I am always struck by the beauty of fern leaves in springtime, unfurling like a crosiers from their tight coils in the debris of last year's foliage. Birth too is both fascinating and beautiful. For me, birth, like the emergence of any new life, is a wondrous, wonder-filled, wonderful thing. The biology of pregnancy, the genetics of inheritance and the parallels between embryology and evolutionary development, intrigue me; so does the brilliance of design in the placenta and the anatomical suitability of the female body to birth. The birth itself, the progressive nature of labour and the amazing accommodation of one body to the emergence of another, is fascinating. The physical, psychological and emotional resources which birth calls for are enormous. To be with a woman as she meets those demands, and witnessing her transformation as a person in doing so, is both humbling and inspiring.

I am a craftsperson. I enjoy making things, I love designing things and problem solving as I go. I knit, I write, I make stained glass windows. That I could, indeed that anyone might, create new life however, is beyond personal skills and intellect. It is something essentially beyond our control, it is something miraculous. We humans have learnt the mechanism of conception and thus we can prevent it. We have not, yet, mastered the creation of life. We cannot 'craft' a human person. We cannot know or control 'who' the person will become. As a species we desire to reproduce, to make babies. We hope and dream of a life and future for them. For me, it is in this desiring, hoping and dreaming, that the miraculous within biology overlaps the aspirations of human endeavour. Wanting and expecting parenthood becomes, at the moment of birth, transformed into the reality and ongoing becoming of parenthood. This is differently experienced, of course, by men and by women; but then all experience, every human life is unique.

I am a midwife. I am 'with woman' in pregnancy, childbirth and in early parenthood. I feel deeply privileged to share in this very special, very significant and very personal human experience. I am always in awe of the creative forces involved, in awe of the human female body's capacity to birth. I am struck and delighted by people's love and concern for each other. I admire the strength, physical, emotional and spiritual, which is expressed so fully in engaged childbirth.

Birth is the culmination of so much expectancy. The mother is traditionally called expectant during pregnancy, but in truth, not only she but her partner, her family, her community are expectant; they await the new arrival. The midwife too as part of the birthing community is expectant. Trying, or not, or even trying not to get pregnant, each have an air of expectation about them. Once pregnant, there are varying degrees of engagement with the as-yet unborn. Then there is the anticipation of labour that signals that birth is immanent, there is the labour itself, each stage heightening the preciousness and significance of the moment of birth. To be present during any or all of this cannot but bring a degree of engagement in the process by the birth attendant. The closer I am to the woman and her personal expectations, the more the birth has meaning for me. That there may be work involved along the way, can make the outcome so much more rewarding. The excitement and the 'magic' of birth is at least as much a product of the social context, the relationships and interactions between those present, as it is a product of wonder at mammalian biology and procreation of the species. Being present and even more, feeling useful at birth is delightful. The woman immediately after birth is usually on a 'high' of prostaglandins and endorphins. Those who have shared her birthing experience, including the midwife, experience a similar elation. There is a sense of having participated in something profoundly human and transformative. The transformation is most evident in the baby, the mother and the family, but it echoes also in the lives of the community and the midwife. Although there can be tragic exceptions, birth is buzzing with anticipation and excitement, it brims over with positive repercussions. Each birth brings with it lessons about oneself, and about life, that may be drawn upon for years to come. Birth, and how we give birth, matters.

A healthy, socially supported, well informed woman will, most often, not need a specialist birth attendant. Birthing is what female bodies do. Midwives trust women to

birth. Yet nothing in life is certain. The holds true of pregnancy, birth and parenthood. In my experience, clinging to the hope of certainty is a futile, even destructive, distraction from the human creativity of living and of birthing. A desire for certainty is, like hope, a human susceptibility. Unlike hope however, the drive for certainty drives out trust. In my experience, and this is echoed in the voices of mothers, fathers and midwives, in this study and others, hospital birth undermines trust in women's, in humans' capacity to birth. In hospitals, trust in birth, in women, in midwives, even in obstetric consultants, is held to ransom by trust in technologies, and trust in 'risk'. Planning to birth at home requires a reorientation away from the now widely accepted distrust of birth that has been normalised in institutionalised birth.

I have experienced the decision to become an independent home-birth-supporting midwife in Ireland, as both liberating and frightening. I have chosen to be more truly 'with women' and to actively trust in, and support their ability to birth. There is a freedom here that I have not experienced in hospital midwifery practice. Trusting in women's ability to birth requires an acceptance of the uncertainty of life and of birthing. This acceptance of uncertainty, is the true essence of the reorientation away from distrust of birth. When I mention fear, it is not a fear of birth itself nor the uncertainty surrounding it. The fear is allied to, but is not in itself, a fear of practicing freely or with professional autonomy. The fear is that, in the course of autonomous practise, I am vulnerable to, and will face the opprobrium of those who distrust birth, or women, or midwives.

I have felt the joy and witnessed the creative and transformative power of birth at first hand. The promotion and support of such good birth is a midwife's *raison d'être*. The structures of hospital birth undermine this possibility. Rather than try to humanise from within that which has become an increasingly inhumane model of birth, I have decided to promote and support a different model of care. Home birth is a minority model, where it once was not, and so is vulnerable to contestation by those who gain from the dominant model. Other midwives have chosen to practise and to seek change within the dominant model. They have their own costs to bear and their own stories to tell. This is the story of independent midwifery in Ireland in the first decade of the twenty first century. It is the

story of my journey towards independent midwifery practice. It is a record of my travels with and amongst Irish home birth midwives.

Introduction

Unusually, I wish to highlight first the central finding from this study which is that supporting women's birthing autonomy is difficult for a professional midwife to accomplish. This is because 'professionalism' assumes a privileged knowledge about or authority over birth. In short, independent midwives find themselves torn between 'being with woman', and 'being professional'. Evidence in support of this conclusion is drawn from the midwives' own experience, and their descriptions of the dilemmas they face in everyday practice.

In the course of this thesis I will elaborate and explain how I have come to this position. This thesis is an ethnography; it describes the culture, the context, and daily lives of independent (self employed) midwives in Ireland at the start of the 21st century. This is 'real world' research (Robson 1993) and so is investigating a very complex social system. Some organisation of the complexity is necessary. As a 'critical' ethnography (Singer 1990, Hammersley 1992), this study will examine or critique the social power relationships between the various actors. A feminist perspective will inform that critique, as will the writings of Michel Foucault which address power generally (1978) and medical power in particular (1973).

Midwifery as a profession lies in uncomfortably close relationship to both medicine and nursing. Any discussion of professions and professionalisation will have to outline their relationship to each other as well as the historical development of birth in Ireland. Midwifery work entails a close physical relation to women, and philosophically midwives position themselves as being 'with women'. Pregnancy, birth and new parenthood, involve significant physical, psychological, emotional, spiritual and social changes for women (and their families). It is in, and through, these changes that the midwife relates to women and performs the activities of her profession. It can be seen therefore that there are diverse perspectives from which to view midwifery work and thus this thesis necessarily draws on the language and writings of many different philosophies and specialisms. The various perspectives and positions held by different writers can be

confusing; they may hold positions that are conflicting, even mutually exclusive. Alternatively, and just as confusing, they may not address each other at all.

The thesis will be structured in the following manner:

Chapter one is a discussion of the decline of homebirth and domiciliary midwifery in Ireland, and the renewed interest in home birth in the setting up of domiciliary pilot schemes in the 1990s.

Chapter two engages with methodological and theoretical issues, beginning with an analysis of ethnography as a methodology that yields a thick descriptive account of social relations. Additionally, as the main framework for the critique or analysis uses feminist and Foucauldian theory, this chapter examines these two perspectives, their language, and the degree to which they might be used in tandem.

Chapter three outlines the day to day practicalities of independent practice, will be followed by a consideration of reflective autobiographical material from my own independent midwifery practice.

Chapter four continues from practical and logistic concerns, to consider the day-to-day relationships that are so central in independent midwifery practice.

Chapter five presents an analysis of some of the discourses that are pervasive in contemporary maternity services including a consideration of why concepts such as spirituality and intuition might be muted in this context.

Chapter six. ‘Being with women’ is a central concept which captures midwives’ work as upholding women’s birthing autonomy. The mother-midwife relationship and birthing autonomy are each examined from the perspective of relational autonomy (MacKenzie and Stoljar 2000) which challenges classical individualistic or atomist conceptions of autonomy.

Chapter seven ‘Being professional’ has many facets, some more to do with advancing the status of the profession (professionalization) than advancing the quality of the service. This distinction is examined. The principle of epistemic authority which underpins the professional project is proposed as the characteristic of professionalism that undermines midwives attempts to promote birthing autonomy.

Chapter eight, like chapters three and four, again relates aspects of independent midwifery practice, but focuses here upon the dilemmas midwives identify as significant in their work as a means for identifying the relationships of power in operation around their practice. This chapter simply describes the dilemmas, leaving critical examination until chapters ten and eleven.

Chapter nine considers particularly the topic of insurance which has two aspects of significance to midwifery practice in Ireland: public / private financing of health services and clinical indemnification.

Chapter ten The dilemmas inherent in independent midwifery practice described in chapter eight (other than insurance) are then examined through the lenses of autonomy and professionalism outlined in chapters six and seven. The vulnerability inherent within independent midwifery practice is presented as deriving from the competing demands to be 'with woman' and 'be professional'. The specific context of independent home birth midwifery practice in Ireland makes this study unique and yet speaks of themes identified in other settings and other midwifery writings. These two aspects, the specific context and the familiarity of the themes, will be examined. Critical ethnography, by asking 'how is it that?' as distinct from ethnography with a purely descriptive 'how it is' focus, identifies power relationships and allows those within and those observing to ask, 'how else might it be?' Some possibilities are explored.

Chapter eleven Concludes the thesis, identifying how a critique of power in contemporary Irish childbirth links to broader social theory.

Chapter One

Situating Home birth and Midwifery in Ireland

In order to be able to understand the experiences of independent midwives I must begin by describing something of the culture and context in which they (we) work. Ireland is an affluent democratic first world country. Each of these assertions would bear considerable sociological expansion, even in respect of health, health services and inequalities, as would Ireland's Catholic and post colonial heritage. The purpose of this chapter is a much more modest examination of midwifery and the maternity services in Ireland which form the more immediate context of the midwives in Ireland who support home birth. Maev-Ann Wren (2003), a sociologist who writes of the Irish health services, asks whether Ireland is more like Boston or Berlin, that is she considers whether Ireland's health expenditure is more publicly funded as in Europe or more privately funded as in the United States. The notion of a two-tier model is particularly relevant to midwifery in Ireland. While midwives in Ireland espouse autonomy and are to a degree self regulating, in practice their autonomy is severely constrained by the policies, procedures and structures of a hospitalised consultant-led model of maternity care provision within which there is a substantial element of private obstetric practice. Midwives deliver almost all of the maternity care to women and are, in the main, the only attendants at birth. In this way the majority of midwives in Ireland can neither be characterised as obstetric or maternity nurses as is the dominant model in the US; nor are they as autonomous as midwives in the Netherlands for example, or those working in free standing midwifery units in the UK.

This chapter attempts to situate contemporary home birth and midwifery in Ireland.

It is not an historical detailing of the development of the midwifery profession, nor a documentary trawl through the legislation regarding birth or birth attendance. These tasks have been performed by others and will be cited accordingly. It is a very brief scene setting that serves to give context and thus perhaps some insight into the experiences and understandings of the midwives who choose to attend women for home births in Ireland in the twenty-first century.

This study is essentially about home birth midwives, but this chapter will, for clarity, consider midwifery development and home birth provision separately. Certainly the two

are closely linked, with the historical course of events in one reflected in changes in the other.

Situating home birth

This section has three parts, 1) a description of the health services in the context of Ireland around the time of the formation of the Irish republic, and the key differences between Irish and British health systems, 2) the decline in home birth particularly through the 1970s, and 3) home birth as a critique of maternity services from the mid 1990s.

Health Services in the new Irish Republic

Ireland gained independence from Britain in 1922, well before Britain developed its National Health Service (NHS). Divergences in the development of the health services have led to there being very different maternity services in Ireland now than in the UK, our nearest neighbour and with whom we share a border. In Northern Ireland for example, free community midwifery care, including home birth provision and postnatal care to at least 10 days and possibly 28 days post delivery, remains as part of the NHS. No such comprehensive service exists in the Republic of Ireland.

Medicine in Ireland has always been, and continues to be, significantly privately funded. Today more than 50% of the population is reported to have private medical insurance (Health Insurance Authority 2008).¹

The oldest maternity hospital in Dublin, the Rotunda was built in the 18th century to serve the very poor and followed early in the nineteenth century, 1826, by the establishment of

¹ From the Health Insurance Authority (2008) market review the following significant points about social inequity are made:

Ownership of private health insurance has remained at approximately half of the Irish adult population in 2007. The breakdown of those having private health insurance by social class clearly demonstrates that the policy of public health insurance leaves the poor more vulnerable and likely then to suffer from any deterioration in the public health service as has been modeled by in the USA.

Social class and age continue to be key determinants of those with private health insurance. For social class, ownership for ABC1 social classes was 73% compared with C2DE at 29%. When examined by age group, health insurance ownership for 35-54 year olds was 57% compared with 39% of 18-24 year olds and 42% consumers over-64 years.

Overall, approximately one-third (34%) of all respondents claimed to possess a medical card or a GP Visit Card (10% of private health insurance consumers and 58% of non-consumers). Approximately 14% of all medical cardholders (with full or partial entitlements) had private health insurance (or 5% of all respondents).

the Coombe. By the twentieth century maternity hospitals also provided the ‘districts’ around them with community midwifery services including home birth (Colgan 1992). The well-off however were attended at birth by doctors in their own homes or in small private nursing homes. Patricia Kennedy (2002, 2004) demonstrates the increasing closure of these small birthing units and increasing centralization throughout the twentieth century. Closure of small hospitals remains a contentious practice and in response to public outcry two midwifery led units were established after closure of two local hospitals in the North East in 2001 (Kinder 2001, Murphy-Lawless 2002). The evaluation of this alternative to obstetric-led care is pending.²

Noel Browne, the minister for health in the 1940s, writes in his memoirs (Browne 1986) of his attempt to set up a maternity service free to all. His proposed mother and infant welfare scheme was radically diminished. The Catholic Church was very influential and expressed concerns about subsidiarity, which is the principle that state support would undermine the family, and that it would open the door to state intervention on reproduction and contraception. Browne also reports that there was a considerable degree of medical resistance to the scheme due to potential loss of their private income. The reduced and means-tested service, the mother and infant care scheme (MICS) introduced by the Health Act in 1953 remained in place until 1991. It was only then that maternity services became freely available to all through the public purse. Ireland maintains a mixed public / private health service. Those on means-tested low income can access free public services through a medical card system. Maev-Ann Wren (2003, Wren and Tussing 2006) gives a critique of the public-private mix in the Irish health system. She is particularly damning of what she describes as the parasitism of the private services upon the public purse. It can be seen that a model of maternity care in Ireland that is largely privately funded predated the Irish state. Women with means and even those without but prepared to try and save, had become accustomed to the idea that they should pay

² The MidU study commenced on 5th July 2004 and the pilot phase ran from then until 31st January 2005, and included 607 women. Recruitment to the main study commenced on 1st February 2005 and ceased on 20th November 2006, with 1653 women included in the trial, 1102 in the midwifery-led care arm and 551 in the consultant-led arm. An independent Data and Safety Monitoring Board conducted an interim analysis on the data received on the first 495 women recruited to the main study (33% of sample). The DSMB decided unanimously that there was insufficient evidence of benefit or harm in either group and that the study should continue as originally designed. Results of the main study are expected to be released in October 2009.

privately for maternity services. The public services continued to be associated with the old dispensary system under the Poor Law (Ferriter 2004). Many continue to pay consultant obstetricians privately for maternity care. This payment is not covered by private health insurance but provides continuity of antenatal care with the consultant. It may not guarantee the doctor's attendance at the birth but having a private consultant may give the woman access to a private bed in the maternity hospital (which is covered by health insurance). Despite doctors' monopoly on access to private (postnatal) beds there are few single postnatal rooms and semi-private 'rooms' may have just one bed less than the public 'ward'.

Home birth is no longer offered as an option by consultant obstetricians or general practitioners (GPs). Some GPs have said that they lack experience of home birth and that litigation dissuade them (O'Driscoll 1983, O'Connell et al 1998). Significantly, GPs have also said (to me, to mothers seeking home birth, and to independent midwives) that they have been told by their insurers to avoid being involved with home birth. As will be alluded to later in the study, the influence of insurance companies in limiting the actions of health professionals and thus limiting the birth choices of women is worrying.

The decline in home birth

There was a significant decline in domiciliary births in Ireland in the second half of the 20th century. In 1955 there were 20,665 domiciliary births out of a total of 61,622 which was 33.5%. Fifteen years later this had decreased more than ten fold to 1,883 domiciliary births out of 64,382 or to just 3% in 1970. By 1980 a further ten fold decrease brought domiciliary births to just 0.3 % with only 202 births out of 74,064 (Kennedy 2002 citing Central Statistics Office data).

This decline reflected the trend throughout the western world with the Netherlands the only major exception.. There was an unfounded belief that birth in hospital must be safer and better than at home. The Peel Report in the UK (1977) and the Comhairle Na nOspideal report (1976) both recommend the availability of consultant-led obstetric care and hospital birth for all women. In Ireland this recommendation, for lack of considered alternatives since, remains Health Service Executive (HSE) policy. However, as Marjorie Tew (1986) put it:

‘Obstetricians ... have become convinced that the natural process of birth is fraught with dangers, which their increasingly sophisticated technological interventions are increasingly capable of minimizing. Amazingly, they have managed, without producing any valid supporting evidence, to persuade the majority of people, medical and lay, that they are right. (Tew 1986: 659)

Tew (1998) demonstrated that much of the improvement in perinatal and maternal mortality measures are attributable to increase in living standards, housing sanitation and especially women’s education and control over their fertility. Finola Kennedy in her book ‘Cottage to Crèche’ (2001) examines the social context of the position of women in Ireland including the position of women in the Irish constitution (Bunreacht Na hEireann 1937) and which goes some way to explaining women’s compliance with Irish State mechanisms including sexist employment practices and services. The status of the unborn child in the Irish constitution also leaves the status of the pregnant woman in something of a contested position. Unlike men and non-pregnant women, the pregnant woman, by virtue of the ‘rights’ of the child within her, has, at least potentially, to face the challenge of her rights, freedoms and choices being contested, constrained or even denied. The politics of reproduction are not unique to Ireland and have been widely debated (Ginsburg 1989, 1995, Weir 2006). Deirdre Daly (2007) has examined the constitutional status of the fetus in Ireland in relation to the ethics of ultrasound scanning. She exposes the lack of clarity about the logical and legal position of mother and baby should their rights come into conflict.³

Layered above the move of birth into the hospital is the increased use of technology and intervention in birth. This is partly due to the general discourse on risk applied particularly to birth (Murphy-Lawless 1998) but also as a result of an industrialized model of birth. This model is typified by active management practices instituted in the National Maternity Hospital (NMH) in Dublin in the 1960s by obstetricians Kieran O’Driscoll and Declan Meagher and exported around the world (O’Driscoll et al., 2003).⁴ A combination of social, cultural and political factors therefore have construed to make Ireland a model of centralized and interventionist maternity services. Not only has home

³ See also Jennifer Schweppe (2008) *The Unborn Child, Article 40.3.3 and Abortion in Ireland: Twenty-five Years of Protection?* Liffey Press Dublin

⁴ Critique of the active management of labour can be found in Goer 1995 and Mander 2001.

birth been discouraged and systems for its provision withdrawn (Colgan 1992), active antagonism to home birth persists. McKenna and Matthews (2003) for example claimed to have compared the safety of home delivery with hospital delivery in Ireland, finding, contrary to rigorously critiqued international evidence, home birth to be ‘unsafe’. The methodological flaws in their work aside (Murray 2004 and MacFarlane 2004), their negative ‘opinion’ about home birth is played out in the responses mothers often receive on enquiring about home birth (O’ Connor 1992, 1995). Home birth antagonism can also be seen in the decision in 2002 by the ‘Masters’ of the Dublin maternity hospitals to withdraw antenatal blood and scans services to women seeking home birth (rescinded since 2008). The persistence to this day of the archaic title of ‘Master’ for the chief executive / clinical officers (CEOs) of the Dublin hospitals, is symbolic and an indictment of the paternalistic, hierarchical and institutional nature of maternity services in Ireland.

Home birth as a critique of maternity services

In 1996, in response to complaints from mothers seeking but unable to access home birth support, a ruling by the ombudsman (Ombudsman 1997) encouraged the health boards to fund a series of domiciliary or home birth pilot schemes.

According to the Ombudsman,

‘The practice of home births (which used to be the norm) has declined in favour of hospital births. As the demand for home births declined, so too did the availability of domiciliary midwives. Many health boards, therefore, found themselves in a position where they were unable to provide a proper home midwifery service.’ Ombudsman report 1996 (1997:28-30).

Three proposals were funded. One, in Galway, was an integrated home birth scheme where home births were facilitated by a group of hospital-employed midwives. A second, in the National Maternity Hospital Dublin (home of the ‘active management of labour’ O’Driscoll et al. 2003) was a combined home birth and DOMINO scheme.⁵ The third, in Cork, was coordinated in the community by an HSE employee but operated by independent self employed midwives contracted to provide home birth services.

⁵ DOMINO – is short for DOMiciliary IN and Out, where ante and postnatal care is in the woman’s home but birth is in hospital.

It is interesting to see that within the hospital schemes, the final evaluations show ten times as many DOMINO deliveries as home births.⁶ In Cork alone, where DOMINO care was not an option, there were twice as many home births as in the other two schemes combined (Domiciliary Births Group report to CEOs (DBG) 2004 unpublished). The preference for DOMINO births could be due to a combination of maternal preference and other structural promoters of DOMINO over home birth, such as limited geographical availability or differential criteria for each type of service. The transfer rate to consultant care was more than ten percent higher for women booked for DOMINO care (36%) than for those booked for home birth (24%) (DBG 2004). This again might indicate tighter initial criteria for planned home birth or that being scheduled for birth in hospital somehow makes transfer to consultant care more likely.⁷

All three pilots, were positively evaluated (DBG 2004, and Southern Health Board (SHB) 2003, Western Health Board (WHB) 2002, National Maternity Hospital (NMH) 2001) and although a national implementation group was suggested, no such group was immediately forthcoming. The Galway scheme persisted for a short while after the period of the pilot (1999-2003) but the service was withdrawn with the money diverted to provide a new neonatologist at the hospital site (Dáil Éireann 2003). This was despite a considerable campaign of protest by local women about the closure (Irish Times 2003, Irish Examiner 2003, Galway Independent 2007).

⁶ Live births by Project (DBG report 2004:17) * non hospital-based scheme

Project	Home Birth	Domino
NMH	66	640
SHB *	207	n/a
WHB	34	345
SEHB	11	346
Total	318	1331

⁷ Transfers from Domino or home birth scheme to Consultant care (DBG 2004)

	Final Bookings		Transfers	
	Domino	Home	Domino	Home
Primipara	467 (100%)	135 (100%)	259 (55%)	54 (40%)
Multipara	814 (100%)	281 (100%)	207 (25%)	44 (16%)
All	1281 (100%)	416 (100%)	466 (36%)	98 (24%)

At the beginning of this ethnography (2006) an inequitable system prevailed with some health board areas willing and able to facilitate occasional home birth services but with most boards only providing a grant towards home birth services if a woman was able to engage the services of an independent midwife. Even that grant was variable and not available in all areas. This led some mothers to challenge the health boards on their compliance with the statutory requirement of health boards under section 62 of the 1970 Health Act to provide midwifery service without charge.

“Section 62 (1) A health board shall make available without charge medical, surgical and midwifery services for attendance to the health in respect of motherhood, of women who are persons with full eligibility or persons with limited eligibility.” (1970)⁸

A Supreme Court decision (O’Brien vs SWHB (South Western Health Board) 2003) indicated however that health boards could not be forced to provide domiciliary maternity services. If the Health Boards (since replaced by the Health Service Executive (HSE)) decided that hospital based maternity services were the preferred model, individuals were not entitled to demand home birth services. The status quo prevailed and differences in home birth provision across the country remained until 2007 when the first tentative steps towards a national domiciliary birth policy were taken. It should be noted that what is proposed is a policy and not a service as such, but this will be discussed more fully in the next section. The grants made available for home birth became payable not to the women but to the midwives under a memorandum of understanding (MOU) between them and the HSE.

Maternity services in Ireland are administered and funded by the acute hospitals sector of the HSE. Although public health nursing (PHN) is funded by the primary continuing and community care (PCCC) sector, and provide the only community support women get other than from their GP, the provision of community based maternity services is minimal. While some PHNs support breast feeding groups and provide antenatal classes, this is not the case everywhere. The PHNs may manage to provide only a single visit (or telephone call) to the mother on transfer home from hospital. The purpose of the visit is

⁸ The eligibility refers to the means tested medical card for free treatment. Free maternity services for all became available in 1990.

to assess mother and baby wellbeing, but largely comprises informing the mother of child health clinics and giving her documentation on child development milestones and immunisation schedules. (Private communication with a PHN and from women’s own reports during the study). The Institute of Community Health Nursing (2007:12) acknowledges ‘the absence of a fully developed and integrated community /domiciliary midwifery service in Ireland’ and ‘the lack of a comprehensive long term plan to meet the needs of these newly delivered mothers and babies’.

The Home Birth Association (HBA) reports that nine out of ten women enquiring about home birth cannot get an independent midwife to attend them (personal communication with the HBA). Wiley and Merriman (1996) in a survey of women’s health found that 5% of women intentionally delivered at home, which seems atypically high but they surveyed women across a considerable age range including those who would have had their babies in the mid 1900’s. But significantly they found that 14% would have liked to have done so. O’Donovan et al (2000) asking antenatal clinic attendees at the Rotunda Hospital in Dublin, report that approximately 10% would consider home birth. Taken together these figures indicate that the demand for home birth far outstrips the availability of midwives to provide that service but also that the HSE by failing to provide a national domiciliary birth service and by focusing its maternity services almost exclusively in hospitals, is denying choice of place of birth to many women who would consider and perhaps even prefer it.

Home birth therefore has remained at the very marginal level of under 0.5% since the late1990s (ESRI / NPRS 2008).⁹ In the Southern Region where there Cork and Kerry

⁹ Derived from ESRI / NPRS Perinatal Report (2008)

Year	Live Births	Planned Home Births	Percentage Home Birth
1999	54,019	246	0.455
2000	54,858	216	0.394
2001	57,922	245	0.423
2002	60,522	288	0.476
2003	61,632	236	0.383
2004	62,067	206	0.332
2005	61,480	183	0.298
2006	65,502	170	0.260
Total for period	478002	1790	0.374

home birth scheme still operates with eight independent midwives, the home birth rate is two to three times higher than nationally at 1.04% (SHB Scheme data and ERSI combined for years 2001 to 2006).¹⁰ It seems that if home birth services are facilitated there is certainly a demand for it.

Situating Midwifery

The history of midwifery has been drawn from as far back as Old Testament story of Moses when the midwives told Pharaoh that the Hebrew women gave birth before the midwives arrived (Genesis 1:19). Medieval European witch burnings too have been referenced as occasions where women healers and midwives were persecuted for their specialist knowledge (Ehrenreich and English 1973). The exclusion of women from the professions during the rise of medicine as an occupation has been well documented and is cited, together with development of hospital institutions, as key mechanisms for (male) medical professional dominance (Foucault 1973, Arney 1982, Hearn 1982, Reverby 1987, Witz 1992). Exploration of this early history of midwifery is beyond the scope of this introduction. I would like to begin instead at the turn of the twentieth century when midwifery first got statutory recognition.

This section will be divided into three parts. The first will consider the relationship between nursing and midwifery. Midwifery's claims to distinction from nursing is a theme in the literature which I argue derives from a professionalizing motivation of midwifery to separate itself from the subservient role of nursing vis-à-vis medicine.

The second part of this section will examine the consequences of the setting up of An Bord Altranais (ABA) the Irish Nursing [sic] Board as the regulatory body for both nursing and midwifery. The third part will examine other aspects of the legislation within the Nurses Acts that situates contemporary midwifery in Ireland. This will include some

¹⁰ Derived from ESRI / NPRS for years 2000 to 2005 and SHB Home Birth Scheme statistics 2006

Total Live Births SHB (Cork& Kerry) Dec '00 to Dec '05	SHB Cork Home Birth Scheme (May '01 to May '06)	Percent Home birth in SHB (Cork & Kerry)
42200	437	1.04

brief commentary on midwifery supervision and professional indemnity insurance which are unique to Ireland.

The status of the nurse

The separation of health provision between the caring and curing aspects is considered by many to be a reflection of a gendered division of domestic and work life (Papps and Olssen 1997, Abbot and Meerabeau 1998, Davies 1998). The professional, money-earning work of medicine, diagnosis and prescription, became legally recognised as the exclusive purview of the doctor and is characterised as ‘curing’. The more domestic and female gendered aspect of physical caring was understood to be, and increasingly became, the role of the nurse. Middle class educated women were afforded a role as handmaidens to the doctor with only the matron in hospital, rising to the heights of domestic administrator manager. The hierarchical and gendered nature of the doctor-nurse relationship is obvious, well researched and documented (Reverby 1987, Hugman 1991). The image of the handmaiden is strongly resisted by contemporary nurses. The hierarchical structures of hospitals and the relative status of medicine and nursing however make it difficult to deny the deferential and subjugated nature of nursing relative to medicine (Reverby 1987).

Midwifery’s claim to distinction from nursing

It could be argued that midwifery is merely trying to articulate its difference from nursing in the hope of resisting the subjugated status of nursing. Let me examine the possible grounds for that claim.

- 1) That there are two persons for whom the midwife is responsible.
- 2) That one of the persons needs special monitoring because it is *in utero*.
- 3) That the woman is well and fully capable of making her own decision about her birthing.

1) That there are two persons for whom the midwife is responsible is hardly a convincing argument for distinction since nurses regularly have charge of a ward full of dependent patients.

2) That one of the persons needs special monitoring because it is *in utero*, is again hardly an argument that serves midwifery which attempts to distinguish itself from the technological advances on fetal monitoring that are promoted by obstetrics and which, in turn, increase intervention rates and diminish a view of birth as normal.

3) That the woman is well and fully capable of making her own decision about her birthing hardly distinguishes her as a health service client, as all health service professions would claim to promote agency and autonomy in their client group.

If it is not then in the nature of the client that the claim to professional differentiation lies, it must be found within the concept of the midwife.

4) Midwives claim an autonomy that is perceived as lacking in nursing because of nursing's subservient relationship to doctors. This is easily challenged by some nurses, or branches of nursing, or specific occupational arrangements where nurses can claim significant occupational autonomy. An example is public health nursing. The dominant occupational arrangement in Ireland, within its large hierarchical consultant-led maternity hospitals, places midwives at the same professional disadvantage as nurses and rightly opens them to the somewhat derisory accusation of being 'merely' obstetric nurses (Brooks et al 1997).

An international comparison of midwifery is beyond the scope of this situating chapter and can be found in Lindsay Reid's (2007) edited collection 'Midwifery Freedom to practise?' Suffice to say here, midwifery in the Netherlands has long been afforded professional recognition and considerable status, and in the United Kingdom the professions of nursing, and midwifery (and previously health visiting) have been separately recognised in legislation and in their (admittedly) joint regulatory body.

The 1950 Nurses Act and establishment of An Bord Altranais

I wish to explore how the formation of An Bord Altranais (ABA), (The Nursing Board) as the regulatory body for both nursing and midwifery in Ireland, has been detrimental to the cause of midwifery in Ireland.

McMahon (2000) covers the history of midwifery in Ireland from 1918 to 1950. The Midwives Act came into effect in England and Wales in 1902, in Scotland in 1915 and finally in Ireland in 1918. With the passing of the Midwives Act (note that this is before

recognition of nursing in the Nursing Act of 1919) the practice of midwifery, or rather more particularly, attendance at birth, was excluded from the population as a whole and limited to doctors and midwives alone or to students of either profession. Midwives had to be registered and, with interim allowance for lack of formal training of traditional midwives, educational requirements and standards were set. Legislation requiring the notification of births (a function which midwives as birth attendants must perform) dates from slightly earlier, 1907, but indicates the concern of the legislature around that time for regularisation of birth (and citizenship). As was mentioned in the section on home birth, the divergence that exists between the status of the midwifery profession in Ireland and the United Kingdom arises from significant changes in statute in Ireland post-partition (1922).

Histories of health services and nursing in Ireland tend to treat nursing and midwifery together, perhaps giving midwifery a separate chapter within the whole (Scanlan 1991, Leahy and Wiley 1998, O'Dwyer and Mulhall 2000, Robins 2000, Fealy 2005). This reflects the reality of the legislation but suggests however that the conflation of the professions is unproblematic. Other Irish authors who explore aspects of midwifery as an emergent profession in Ireland (Matthews 2006, Higgins 2005 and 2007) highlight the conflation of midwifery and nursing in Ireland as a significant feature in the subsequent development of midwifery in Ireland.

Although ABA is the statutory regulatory body for both nursing and midwifery, midwifery is written out of the title in English and '*as Gaelige*'. This 'writing out' is in line with the 1950 statute which set up ABA and amalgamated the separate governing bodies for nurses and midwives. ABA cites Irish statute which persists in making midwifery invisible by conflating the terms nurse and midwife.

'The word 'nurse' means a person registered in the Live Register of Nurses as provided for in Section 27 of the Nurses Act 1985 and includes a midwife and nursing includes midwifery.' (ABA code of professional conduct 2000)¹¹

¹¹ Matthews (2006) argues that the wording of the Nurses Act 1950 which set up ABA, and which subordinates midwifery to nursing, was the product of a redrafting of the act which had originally proposed the term 'maternity nurse' instead of midwife. It was argued at the time that denominating an Irish midwife

Matthews (2006) in her PhD study of midwifery empowerment, relates the story of the dissolution of the central midwives board as the regulatory authority for midwives, and the setting up of ABA. She describes the central midwives board's attempts to resist abolition before 1950 as 'attempts to retain power'. She documents 'the unsatisfactory position of [the] Statutory Midwives Committee [of ABA] which has arisen resultant on the limited powers of the committee' after 1950 and describes their ultimately unsuccessful 'attempts to regain power'. In the 1985 Nurses Act the Statutory Midwifery Committee was disbanded. In 2003 a non-statutory midwifery committee as set up 'in keeping with the spirit of the commission on nursing' (ABA 2003:11 cited in Matthews 2006) and pending the still awaited (in 2009) Nurses and Midwives Act.

The Commission on Nursing

The discomfort of nursing and midwifery as bedfellows has been discussed by many commentators (Cameron and Taylor 2007, Norman 2007, Thompson et al. 2007) A Commission on Nursing (DoH&C 1998) set out to investigate the principle concerns of the nursing and midwifery profession in Ireland. It was a very comprehensive investigation of the status of nursing and midwifery drawing on submissions from many stakeholders.

The call by midwives for separate recognition of midwifery was noted and was a main recommendation. It is largely as a result of the commission that proposals for changes in the legislation regarding nursing and midwifery governance and nurse and midwifery prescriptive authority (to be discussed later) have arisen. Independent midwives, who rarely met together as a collective did so to make a submission to the commission (Independent Midwives 1998).

The commission on nursing identified the lack of a clinical promotion structure in nursing and midwifery as a disincentive to stay within the profession. Prospects for

as a maternity nurse would have diminished her role and made her ineligible to work as a midwife in Britain (Browne 1986). The word midwife therefore was reinstated but without altering the remaining text. The clearly intended newly drafted (1950) act retained something of the intent in the wording. Thus midwifery in Ireland has been hampered by a typographical error which has continued in the legislative wording ever since.

professional advancement in nursing and midwifery are largely limited to management or education, causing a drain of expertise from the clinical setting. The National Council for the professional development of Nursing and Midwifery (NCNM) and Nursing and Midwifery Professional Development Units (NMPDUs) were set up to address these issues and proposed promotional cadres of clinical nurse (or midwife) specialist (CNS / CMS) and Advanced Nurse (or Midwifery) Practitioners (ANP / AMP). They did not propose a cadre of nurse (or midwifery) consultant such as exists in the UK.

While this model has been successfully adopted by nursing, specialism (specialisation) as a means of professional advancement has not been so warmly welcomed by midwifery. Many midwifery practitioners and educators express reservations about specialisation in midwifery. Specialism reflects too much the model of medicine, and undermines the generalist skills which promote continuity of care and relationship with women. Specialism tends towards fragmentation of care and the relative deskilling of those not deemed specialist or advanced practitioners. There was great concern amongst midwifery academics, managers and clinicians that any AMP position should be in the promotion of normality in pregnancy and birth (Begley et al 2007)¹². The argument is that generality of midwifery skills supports normality, which is the central precept of midwifery care. AMP positions that have promotion of normality as their focus have been hard to devise because the whole thinking behind ANP / AMP positions was predicated upon specialism. As yet (2009) the one AMP position with a normality focus (in Waterford) remains unfilled. The only other two AMP posts are in diabetes care and in urodynamics / continence care. These are specialisms more akin to medical specialities and it is hard to see these positions escaping from the doctor-dominated hierarchies sustained in hospitalised maternity services. A clinical specialist model does not suit midwifery and so midwifery has yet again been disadvantaged by a promotional structure that values and sustains nursing and medical hierarchies.

Midwifery education

Matthews (2006:128) cites a memo sent to An Bord Altranais members in 1955 that notes the 'regrettable diminution of interest in all matters relating to the practice and training of

¹² The concepts of normality and abnormality in pregnancy and birth are discussed in chapter five.

midwives.’ Furthermore, she describes the near loss of separate midwife training and the proposed demotion of midwife to maternity nurse in Ireland in the 1950s. She tells how this move was prevented only by the reciprocal recognition, between Ireland and the UK, of nurses’ and midwives’ education and registration. Thus it seems that it is only as a consequence of Ireland’s relationship to the UK and later membership of the EU (in 1970) that Ireland has maintained any semblance of a midwifery presence and a voice for midwifery. The regulation of midwifery education is a statutory function of ABA. The education committee of ABA has used EU legislation for interstate recognition of the profession, to keep standards, at least of midwifery education, in line with that in the rest of Europe.

With the reduction in the numbers of home births from the 1950s to the 1970s, the requirement for home birth or domiciliary midwifery experience as a student dropped from 10 home birth to 5 and then to zero (Colgan 1992). ABA has after many years reintroduced a requirement for community midwifery experience into its standards for midwifery education (ABA 2000b).¹³ The limited opportunity for such experience is a problem that means every midwifery educational institution will have to struggle to achieve this requirement. There is the possibility that between this ABA initiative, and a memorandum of understanding (MOU) between the HSE and the independent midwives developed in 2007¹⁴, may make opportunities for students to work with midwives at home births more likely.

The Education Committee of An Bord Altranais oversaw the setting up in 2000 of the direct entry pilot programme for midwifery (initially a three year diploma, now a four year undergraduate degree commenced in 2006). Attempts were made by Margaret Carroll,¹⁵ who devised the programme, to incorporate community / domiciliary practice experience with independent midwives as part of that programme but funding limitations undermined the goodwill of all parties to such an initiative (Carroll and Begley

¹³ This two week community experience was introduced only into the direct entry undergraduate degree. ABA 2000b:15

¹⁴ The development of the MOU by the Domiciliary Birth Implementation Group (DBIG) is described in chapter four section three.)

¹⁵ Margaret Carroll was a midwife teacher in The Rotunda Hospital and is now senior lecturer in Midwifery at Trinity College Dublin School of Nursing and Midwifery

2003:119). The rollout of the direct entry programme as a third level, four year degree, saw the reduction of postgraduate (post-nursing) midwifery education from two years to eighteen months. Patterns in the UK would suggest that the latter mode of entry to midwifery will decline. Where once dual qualification in nursing and midwifery was seen as a means of securing permanent and senior positions in hospitals or public health nursing position, this is no longer the case. PHNs, since 2007, are no longer required to have midwifery registration and can instead complete a mother and infant care module (ABA 2005). This further undermines the position of PHNs as appropriate supervisors for independent midwives which has already been highlighted as problematic (Institute of Community Health Nursing 2007, DoH&C 1998).

The need to ‘control’ midwives

Determining whether the conflation between nursing and midwifery facilitated, or arose from, the hospitalisation of maternity services in Ireland is beyond this thesis and may be a chicken and egg question. What is evident from the work of McMahon (2000) is that midwives’ failure to conform to the subservient status of nurse as handmaiden resulted in harsher treatment of midwives by their own regulatory body even before the formation of ABA. McMahon (2000) in her examination of the regulation of midwifery in Ireland from 1918 to 1950, is very persuasive in arguing ‘the punitive nature of surveillance and regulatory function of CMBI’ (Central Midwives Board Ireland) which held 52 penal cases in the period whereas the same Nurses Act function was not initiated (McMahon 2000:56).

McMahon’s examination of the documents of the time reveals differential reaction to nurses and midwives amongst doctors.

‘midwives were ‘uneducable’’ whereas nurses were ‘supportive, deferential and acceptable colleagues for medical practitioners’ (McMahon 2000:57 citing W Blair Bell, *Lancet* 13th June 1931:1279-1286)

Furthermore ‘impertinence’ to the doctor was cited in a midwifery case in CMBI minutes (McMahon 2000:82). McMahon also notes that, given the makeup of the central midwives board ‘the regulation of midwives did not permit professional practice

controlled by midwives' (McMahon 2000:90).¹⁶ Similarly the new ABA had only 3 midwifery representative out of 23 members, one being a master or assistant master of a maternity hospital and two being midwives (Matthews 2006).

This pattern of surveillance and regulation of midwifery suggests a particular resistance to midwifery arising from professional or occupational competition. Marsden Wagner (2007) considers that obstetric resistance to unorthodoxy in its own profession is all part of a professionalizing project to control birth. Wagner argues that this dominance, this desire to control underpins and is enacted in the prosecution, even 'witch hunting' of independent midwives internationally.

'there is a global witch-hunt in progress – the investigation of health professionals in many countries to accuse them of dangerous maternity practices. This witch-hunt is part of a global struggle for control of maternity services, the key underlying issues being, money, power, sex and choice'. (Wagner 2007:36 -37)

The term 'witch hunt' has been used by other midwifery authors (Wagner 1995, Beech and Thomas 1999, Jowitt 2008) and will be seen again in the stories from the independent midwives in this study who sense that they are unfairly persecuted in Ireland by obstetricians and by ABA.

Witch hunting, or any less contentious interpretation of the treatment of independent midwives practicing in a fully autonomous fashion, can be construed as an expression of occupational rivalry between medicine and midwifery. Harsh treatment of midwives by their own (though conflated) professional body however can also be considered to be as a result of professionalization. A non-independent midwife colleague of mine has remarked at how 'nurses and midwives eat their own young'. She compared ABA's fitness to practice (FTP) hearings to doctors' professional hearings which she considered to be much more sympathetic. This leads me to wonder why nurse and midwives should be so ardent in the pursuit of professional process and in protecting their good name and public reputation. Explicit enforcement of professional standards to protect the public serves

¹⁶ The Midwives Act (1944) legislates for the midwives board membership. There are 11 board members, 7 appointed of which 4 were midwives ('on consultation with representative *nursing* organisations') and one Doctor. There were 4 elected members, all doctors, so the midwives were outnumbered by doctors on their own regulatory board.

<http://www.irishstatutebook.ie/1944/en/act/pub/0010/sec0009.html> accessed 6th September 2009

also to legitimise the professional body as professional. Could it be that enforcement of standards serves to secure the professional status of the occupation of midwifery amongst other competing occupations? As exercises in legitimisation, FTP hearings are at least as much professionalizing in their function, as protective of the public. If membership of the FTP panels are made up of nurses or even hospital based midwives, (rather than independent community or domiciliary practitioners) is there a possibility that occupational demarcation is a confounding factor in the processes and the ultimate outcome of those proceedings?

It is interesting to hear, even in the talk of independent midwives themselves, of how independent midwifery practice, but more particularly independent midwives appearing before ABA, draws opprobrium upon midwifery and by association upon nursing. It is interesting that independent practice, by virtue of its unorthodoxy, thus has the potential to undermine the already tentative and subjected status of 'professional'. Casting out of individuals who might compromise the reputation of the whole profession, is scape-goating. I feel it is not a coincidence that those midwives who most closely challenge medical authority over birth, perceive themselves to be most vulnerable to obstetric critique. They also feel ill served by their own professional body and vulnerable to its punitive and to their mind biased critique.

Other aspects to the context of midwifery in Ireland

Supervision

Midwifery supervision, indeed professional supervision has become something of a watchword amongst the professions in the past decades. Psychotherapists particularly use a supervisory model where practitioners are required to spend some considerable time reviewing their practice with experienced senior colleagues. Within the Nurses Act (1950, last amended in 1985) there is a requirement for the health boards (now the Health Service Executive HSE) 'to exercise general supervision and control over' midwives (section 57.2 of the 1985 Nurses Act).

When there were significant numbers of home births and community midwifery services, this supervisory function was carried out by Director Public Health Nurses (DPHNs).

PHNs were required to have a midwifery qualification as they also provided midwifery care in the community. They were also likely, as part of their training and work experience, to have attended home births and have understood the demands of that work. With the decrease in home births, particularly after the 1970's, PHNs qualified after this time would have had little or no domiciliary midwifery or home birth experience but still have hospital midwifery experience. The independent midwives report that supervision up to the 1990s was sporadic and variable, sometimes being no more than an annual chat and inspection of the contents of their midwifery bag. In the 1985 Nurses Act the requirement for all midwives to report their intention to practice (to their local Director of PHN) was withdrawn, except significantly, for those working in the community. This is presumably because working within the hospital sector, most midwives have some sort of managerial structure and notionally therefore also supervision. Independent midwives continue to notify their intention to practice since 1985. They report however they have not been 'properly' supervised since the mid 1990s and those, like me, who started home birth practice since 2000 have had no formal supervision whatsoever.

The professional body for PHNs, the Institute of Community Health Nursing (2007) has clearly stated its concern and disinclination for PHNs who now rarely have midwifery experience and certainly not in a community setting to perform this supervisory function (also highlighted by the Commission on Nursing DoH&C 1998). Current cohorts of PHNs no longer even have to have a midwifery qualification which further highlights the inappropriateness of midwifery supervision by PHNs (ABA 2005).

While McMahon (2000) talked about the severity of regulatory function at the start of the twentieth century and various authors in the UK have critiqued negative examples of midwifery supervision (Demilew 1996), contemporary Irish domiciliary midwives no longer have a state sanctioned role and no formal means of accessing support despite the requisite legislation being in place. Sheila O'Malley (2002) examined the subject of midwifery-led care and focused particularly upon supervision as a mechanism for ensuring quality care. She highlights the deficiencies in the Irish maternity services and proposes that if midwifery-led models are to become part of Irish maternity care provision that supervision of midwives must become an integral aspect.

INO / professional bodies

Midwives in Ireland have no professional body that is run by midwives for midwives with professional issues as their central concern. An Bord Altranais, the regulatory body has been mentioned, and while it provides codes, guidelines and standards documents, it is not a forum for discussion or personal professional support of individual practitioners. The main trade union for nurses and midwives is the Irish Nurses Organisation (INO). (Again note the absence of midwifery in the title, though after considerable resistance from its membership in recent years the INO have resolved to change their name to include midwifery. It will remain the INO until the long proposed Nurses and Midwives Act becomes statute. Amongst other things, the Nurses and Midwives Act proposes to undo the writing out of midwifery that happened in the 1950 Nurses Act.)

The INO midwives' section has attempted to address issues of a professional nature using the considerable resources of the larger union but this has proven difficult as INO structures and concerns are largely of an industrial relations nature. The INO however do support an annual cross-border conference with the Royal College of Midwives (RCM) in Northern Ireland and also support INO midwife section members to represent Irish midwives at European and international midwifery forums.

A very small group called the Midwives Association of Ireland (MAI) did set up some years ago and succeeded in becoming recognised by the International Confederation of Midwives (ICM) as a representative professional body for Irish midwives along with the Midwives Section of the INO. The MAI however has been unable to attract broad support for its professional aims.¹⁷

Insurance

Nurses and midwives, in common with other professions, are expected to be indemnified for their practice. Health service litigation costs in Ireland are considerable. (Birchard 1999). In 2002 the state claims agency (SCA) clinical indemnity scheme (CIS) was set up to provide a more cost-effective way of dealing with litigation than through individual private legal proceedings (State Claims Agency 2009). The scheme applies to all state

¹⁷ In June 2009 the MAI withdrew itself as a representative body to ICM.

health bodies and employees with the exception of GPs who are considered to be private contractors. Proposals that separate insurance cover should be a requirement for private consultant practice was very strongly and successfully resisted by doctors with mixed public private contracts.¹⁸ This public-private mix in medical contracts is still contentious and contested between the current (2009) minister for health Mary Harney and hospital consultants. Insurance for non-hospital midwifery and nursing practice continued to be covered by trade union membership until, in 2007, the INO announced that they had been advised by their insurers that they should withdraw indemnity cover for home birth. A similar decision had been made in 1994 by the Royal College of Midwives in the UK and many independent midwives are reported to have stopped doing home births as a result (McHugh 2009). While some continue to practice without insurance, such is the arrangement of the NHS community midwifery service in the UK, that most home births are provided by NHS-employed and indemnified midwives. While the RCM recommend that independent midwives be indemnified, it is recognised that insurance companies either refuse to provide any cover or charge premiums unsustainable on a midwifery income. The very real possibility is that EU or national statute or professional bodies (the Nursing and Midwifery Council NMC in the UK, and An Bord Altranais ABA in Ireland) will pronounce it illegal for a professional to practice without insurance. The consequence is that ‘minority’ and, from the point of view of private insurance companies ‘unprofitable’, occupational practices such as home birth will thus be made illegal. (This has recently been announced in health legislation amendments in Australia (Licqurish 2009). Women’s choice in birth, and many other social practices, thus become increasingly subject to actuarial for-profit calculations in a risk-averse society. These arguments were put to the INO, to the HSE and to the health minister (Mary Harney) by the independent midwives in their petitions against insurance withdrawal.

The Domiciliary Births Implementation Group

The previous section situating home birth in Ireland mentioned the setting up of three pilot projects to facilitate home birth. These pilots were positively evaluated by the Domiciliary Births Group whose report to the CEOs of the health boards (DBG 2004)

¹⁸ The majority of hospital consultants (and obstetricians) have this type of contract, see Wren (2003).

was never formally published but has been described by the DoH&C as ‘a dynamic working document’ and can be accessed through the HSE archives.¹⁹ One of the main recommendations of that report was that a domiciliary birth group be set up to implement its recommendations nationally.

No such group was convened until the insurance issue became an acute problem for the midwives, the INO, and in turn then, the HSE. In 2007 the Domiciliary Births Implementation Group (DBIG) was set up by the HSE. While its fuller remit (arising from the 2004 report) was to consider national domiciliary midwifery and home birth provision, the immediate, and in the end the only function of the DBIG was to ensure a mechanism for the indemnification of independent home birth midwives under the state claims agency clinical indemnity scheme (SCA CIS). Indemnification of independent midwives was facilitated by a memorandum of understanding (MOU) which will be discussed at greater length in the main body of the thesis. As a result of government initiatives on equity and fairness in the development and implementation of its policies (DoH&C 2001a), there was independent midwifery and maternity user group representation on the DBIG. A concern for protecting women’s birth choices seemed to guide the DBIG, but there was no commitment on the part of the HSE to make home birth available to all women, or to promote home birth in any way beyond facilitating (and governing) those few independent midwives who choose to work outside the hospital system.

Chapter summary

Home birth in Ireland has been all but eradicated by Department of Health (and Children) policy of hospital birth which was founded upon unsupported claims to better outcomes under consultant obstetric management. Although primary health care is supported in governmental rhetoric, so centralised and institutionalised have maternity services become that a restoration of primary /community care is structurally difficult and given resistance to changes in the status quo, unlikely. The flaws of fractured, discontinuous maternity services, high levels of intervention and obstetric control of birth have been

¹⁹ Available through LENUIS Irish Health repository <http://www.lenus.ie/hse/handle/10147/44701> accessed 5th September 2009

documented widely and internationally. A very risk-averse, possibly even risk-phobic culture pertains in obstetrics internationally and yet maternal and perinatal mortality outcomes are on the whole comparable between hospital and home birth. Some babies will inevitably die whatever the place of birth. This is an unacknowledged fact in the promotion of hospitalisation ‘just in case’. Yet perinatal / neonatal death is the major cause of fitness to practice investigation of independent midwives by An Bord Altranais suggesting perhaps a blame culture in relation neonatal death at home. An alternative interpretation might be that the HSE’s derogation of its duty to supervise and control (independent) midwives has led to a lack of governance structure and transparency in their operations that leaves no mechanism short of ‘fitness to practice’ (FTP) review for the investigation of ‘unfortunate’ outcomes. Fitness to practice review, with its statutory powers, *in camera* hearings and legal representation is perhaps unnecessarily adversarial and punitive. It is therefore inappropriate, but unfortunately it remains the only means for investigating midwifery practice outside hospitals. It is a poor substitute for proper professional support and supervision for midwives. It does not and cannot serve midwives facing the challenges of supporting women who want home birth in a context where the dominant maternity service professionals are adverse to it.

Presentation of midwifery as a ‘branch’ of nursing has promoted a perception and treatment of midwives in Ireland as obstetric nurses. This presentation is challenged in midwifery educational and philosophical rhetoric but the challenge has little real influence on clinical practice.

The combination of hospitalisation of birth and the subservience of midwifery to obstetrics in institutions, has undermined midwives’ autonomy and limits their experience of normal labour. Midwives learn to fear birth but even when they reject fear of birth itself, they recognise that independent practice is subjected to severe critique which inspires fear for their registration and their professional status. Working in a fearful, fractured and hierarchical birthing environment is itself stressful but such are the impediments to independent practice that very few take the step away from hospital practice. Irish Supreme Court ruling (2003) has absolved the Health Service Executive from the need to provide choice and so home birth goes un-promoted. Women choosing to avoid the interventions associated with Irish maternity services must source a midwife

themselves. Almost all of the very few independent midwives in Ireland have had some considerable education or practice experience outside Ireland. Exclusively institutionalised birth practices have become the norm through the influence of medicine and obstetrics in the structures of power in Irish (health) politics. Absence of midwifery autonomy both as a profession subsumed under nursing and individually within institutional structures, has undermined midwives' availability to women seeking alternatives, both within and outside hospital. Ireland has been slow to foster the broad middle-class support for changes in the birth environment such as underpinned the moves towards the UK policy, 'Changing Childbirth' (Department of Health UK 1993) and it is arguable that this slowness is attributable to the majority of middle-class women opting for private obstetric antenatal care. The absence of a choice lobby in reproductive issues is characteristic of a society still marked by institutional patriarchy (O'Connor 1998), as is the continued subservience of nursing and midwifery to medicine and the persistence and apparent acceptability of titles like 'master' for the senior obstetrician in the Dublin maternity hospitals. Midwives who operate independently in Ireland face these contextual attitudes and obstacles. Their women-centred philosophy constantly meets with a system that not only does not embrace it, but actively refutes and refuses women's birthing autonomy. They contend with a system that opposes autonomous midwifery practice.

Chapter Two

Methodology

Introduction

This is a study by a midwife about midwives, and by extension, about midwifery. It hopes to contribute to ‘knowledge creation’ by bringing the knowledge and experience of some midwives to the fore for examination and analysis. I have considerable sympathy with Elizabeth Smythe’s assertion (1998) that the philosophical pervades the methodological. The effect of one’s philosophy of human ‘being’, which is an aspect of ontology, and one’s beliefs about the possibilities (or limits) of human ‘knowing’ and ‘truth’, which is epistemology, overarch and permeate all aspects of the research method and its theoretical justification, which is methodology.

This chapter is divided into seven sections and each section describes a different aspect of the study methodology.

Section one will discuss the breadth of the research question.

Section two is a short autobiographical piece that serves several purposes. It explains, somewhat, the motivation for the study and the nature of the research question.

Section three will describe and identify rationale for ethnography and particularly autoethnography as methods used to gather data in the study.

Section four rather artificially separates data collection from analysis but it serves to outline aspects of the analytic process that derive ‘findings’ from the raw data.

Section five examines the main conceptual framework for the analytical critique. A feminist perspective and Foucauldian theory inform the critique. This section of the methodology chapter examines these two and investigates how they might be used together to support this critical ethnography.

Section six outlines some ethical considerations in relation to consent and naturalistic enquiry.

Section seven ends the chapter with a description of the study participants, the study duration, the amount, and type of data collected. It uses the theory explored in the first sections and describes how they were put into practice.

Section One The research question: a justification

There are many research questions one could ask of home birth midwifery practice in Ireland. As many writers have articulated, perhaps most notably Kuhn (1962), in his description of ‘normal science’, the questions one asks depends on what knowledge or epistemological paradigms one is operating within, and what tools already exist for answering those types of questions. In some constructions of knowledge, a theory precedes the question and a hypothesis is offered which can be tested. In this study, no testable theory precedes the study; the research question is open and exploratory. In essence it stands as ‘What is it like to be an independent home birth midwife in Ireland in the early twenty first-century?’ One might also phrase it this way: How do midwives navigate the demands of practice within the context of their domestic and professional lives? I have not asked and will not report how much a midwife earns, or what their individual or collective perinatal mortality rates are. These questions might or might not occur to others as valuable or answerable. I have however to declare a reluctance to expose the midwives, myself, and the entire home birth and midwifery movement, to inappropriate criticism based on inappropriate methods and questions. This study falls well within an interpretative paradigm and, as with any human endeavour, the study itself and I as its primary tool and narrator, are contingent upon many factors – including my own historical and developing biography. The narrative presented here, will attempt to integrate the ethnographic description I have gathered during my contact with others, with a reflexive autobiographical account of my own becoming and being a home birth midwife.

Section Two The researcher as data collection tool: a biographical synopsis

This section provides some basis upon which you, the reader, can judge me, the author. I am the primary data collection tool and it is my interpretation of that data that forms the body of the narrative description. The data collected is dependent, for good or ill, upon my relationship with the other midwives. The concept of researcher effects upon relationships in the field (reactivity) is discussed in section seven.

As will become clear, this study is both ethnographic and autobiographical. It could be argued that any ethnography is autobiographical to an extent, whether the author's finished work acknowledges that or not (Van Maanen 1988). The short biography therefore serves also to signal the ongoing inclusion of explicitly autobiographical material amongst the ethnographic data. My concern at this stage is that, thus far, the midwives themselves have not been heard but I intend that theirs will form the bulk of the material throughout.

I am in my forties, the eldest of eight children and can remember my youngest siblings being born at home. My mother was attended by our GP and the local midwife, Kitty Boden, who each lived only a short distance from our home. Home birth and breast feeding were very normal to us, though few of our friends would have been familiar with either.

After completing a science degree, I trained as a nurse, but I found that there was not enough time, were not enough resources, to nurse, to care, properly. Inadequacies of both the system and the people working in it, made the human interaction and caring perfunctory, dissatisfying and disheartening. The human characteristics of loving and caring, had to be spread so thin that the shortfall between need and availability became a major stressor. The crux though in relation to emotional burnout seems to me to lie not in the giving (Maslach and Jackson 1986, Hochschild 2003) but in the necessary emotional withholding where time and other 'resources' are thin.²⁰

During my nursing studies, I spent some weeks in a maternity hospital. There, it seemed to me, healthy women were doing a healthy and miraculous thing. Birth, which is undeniably earthy, animal, hard work, is wonderful, and it was wonderful for me to be there at such an emotional and creative time in other's lives. It was at birth, where there was (generally) one midwife to every woman in labour, that I saw that the midwife can give his/her all to and for the woman. Who, and how you are as midwife and as person, seemed to make all the difference to the shared birth experience. This uncompromised, 'being with' was so different to my nursing experience. The experience of being able to

²⁰ Pam Smith (1992) describes student nurses expressing the same systemic obstacles to caring.

give; to care not just physically but emotionally, was immensely satisfying.²¹ A significant additional attraction to midwifery came in the form of a rhetoric of midwifery as autonomous practice (like medicine) which pervaded the talk of midwives, or at least of midwife teachers. Though not clearly played out in every interaction, the possibility of these two aspects, the 'being with' and the rhetoric of professional autonomy, was overwhelmingly new and attractive. Midwifery seemed to, and still does, hold the potential to satisfy me, the practitioner, in ways that nursing could not. Nursing has limited autonomy even at its most technically skilful and in well-resourced environments, and the caring relationship seems to focus on and reward technical instrumental rationality rather than emotional caring and relationality.

So I trained to be a midwife and I worked for four years in the labour ward in my training hospital before going to Malawi in south east Africa for two years as a nurse and midwifery teacher. This again was a wonderful experience, I enjoy teaching and I participated in normal, twin and breech births which would have been very unlikely in Ireland, where medical intervention in such births are very common. My Malawian experience helped me to see how very privileged my life in the developed world had been. In Ireland, even the poor have comparatively good access to health and maternity services.

I returned to a midwifery teaching post in Dublin, and while there was opportunity for some clinical experience supporting student midwives in the hospital, this was limited, and there was little chance to be with women in labour. I missed practicing 'real, hands on' midwifery. The protected, one-to-one ratio of midwife to woman seemed to be difficult to organise, and a conveyor belt mentality, a managed and highly interventionist approach to birth dominated. Midwifery care was very fragmented, as is common in hospitals, with outpatients, antenatal wards, postnatal wards and labour or delivery suite each having different cohorts of staff. My one attempt to work a week of nights on the labour ward was extremely difficult as an atmosphere of anxiety and control of birth

²¹ Midwife job satisfaction is related to the ability to build a meaningful relationship with the women in their care. This has been demonstrated by many authors including: McCrea and Crute 1991, Rothman 1991, Carlisle 1994, Bakker et al. 1996, Sandall 1997 and McCourt and Stevens 2008.

pervaded. Women seemed to come into the hospital in a disempowered, dependent state. It seemed to me that the women, the midwives and even the obstetricians, were fearful of birth and compliant to the needs and disciplines of the hospital system. It seemed to me that the only persons speaking the language of women's and midwifery autonomy were the midwife teachers, and the only one living that rhetoric, 'walking that talk' was a colleague who worked part-time as an independent midwife doing home births.

I decided therefore to try to construct a situation whereby I could practice midwifery and simultaneously carry out relevant midwifery research. I applied for and was fortunate enough to win funding for a three-year doctoral study into independent home birth midwifery in Ireland. With funding to release me from my teaching responsibilities, I could have undertaken a simple study of others' practice. That might have been the wise move, but instead I reckoned that it would be difficult to convince myself, and others, that I was more than just 'pro' home birth but actively committed to it, unless I put myself in the position of actually providing home birth support for women. I needed to live up to my own rhetoric of challenging institutionalised birth and championing the autonomy of midwifery practice.

Now you have some measure of the major research tool. There are many elements that are likely to have reflexive effects, effects which may influence the research field, and the relationships built with the other independent midwives, who are the main informants or participants. Reflection upon some of the most obvious factors such as my gender, my background as midwife educator and my frank admission of pro-homebirth partiality, will be necessary. For now however, a broader discussion of methodology will be presented.

Section Three Ethnography and autoethnography

The qualitative/quantitative research debate has been rehearsed for decades with most now recognising the utility of both, and acknowledging that separation of the two as distinct is tempting but artificial (Oakley 2000). Research methods might be considered to be on a continuum between the highly controlled and quantified and the more

interpretive. Methods should be chosen for their utility and appropriateness to answer particular research questions.

The dominant methods of the scientific rationalist, the experiment and randomised controlled trial, are not appropriate for investigating questions about human motivation nor, for the very specific, contextual and relational world of human interaction, interpersonal communication and decision making (Robson 1993). These contextual and relational questions are what need to be asked of community domiciliary midwifery.

The ongoing, highly contextual and relational nature of the study is more consistent with the philosophy of ethnography than other qualitative methods such as phenomenology, grounded theory or action research. Each of those methodologies could be used to explicate aspects of the phenomenon, or the process, but could not be as open to the description of the immersion, the interactions between individuals, and the broader sociological context, that make up the whole ethnographic picture (Streubert and Carpenter 1999).

Giddens (2001:646) describes ethnographic research as seeking ‘to uncover the meanings which underpin social interactions; [...] through the researcher’s direct involvement with the interactions which constitute social reality for the group being studied.’ Ethnography involves immersion in the culture and context of the observed, and listening to the voice of the participants in their context. ‘Ethnography is the study of people and groups at first-hand over a period of time, using participant observation or interviews to learn about social behaviour.’ (Giddens 2001:646) Participant observation requires taking part in the group’s daily activities, asking for explanations or insights into decisions, actions and behaviours. To try to understand the how, and perhaps even the why of independent midwifery, ethnography is an appropriate methodology.

Ethnography is eclectic in its data collection methods and its sources. The perspectives of obstetricians, hospital-based midwives, GPs and health service planners would all be relevant to the field of maternity service provision and home birth. Each would bring his/her understandings, meanings and influences. I decided however, to limit observation or focus to the midwives themselves rather than the much broader field and context of maternity services in Ireland, which might balloon into a project far too wide in scope to be contained within the parameters of a single study.

Since participant observation was to be limited to midwives, data on the broader culture and context of home birth and independent midwifery practice must therefore come from other sources. Such data are available for example through newspaper articles, editorials and letters and from health service reviews and policy documents. Other artefacts from the field such as letters to and from GPs, health boards, maternity hospitals, obstetricians and midwifery managers, health insurance funding agencies, medical suppliers, etcetera provide documentary evidence.

The very relevant but entirely different consideration, of women's views of home birth and the midwife's role, might be sought and would certainly provide context, but again would considerably expand the scope of the study. Permission to be in the woman's home for the purposes of observing and recording their relationship was requested, and given, but formal focus on the woman's perspective was not the purpose of this study. The work of Marie O'Connor (1992, 1995) and Jo Murphy-Lawless (2002) in Ireland and Nadine Edwards (2001, 2005) in Scotland, and many others have explored women's perspectives and their work offers some insight and contextual referents to this study.

Ethnographic description

The principle that ethnographic description should be 'thick' (Geertz 1973), that is, very detailed, has several functions. Hypotyposis, the vivid description of a scene or event has been described by Campbell (2000) as a rhetorical device. It gives the impression of verisimilitude which gives legitimacy to the author and helps the reader to feel or judge the reality of the scene. It also then clearly forms the basis from which knowledge, conceptualisation or theory is derived. Unfortunately, in any scene or setting there are infinitesimal details that could be drawn upon. As the saying goes, a picture says a thousand words; any description must necessarily be only partial. I have wondered whether a series of videos might not better capture the complexities and subtleties of home birth and the mother-midwife relationship. Indeed several such video documentaries exist.²²

²² Examples are: Born by Andy Lawrence with Judith Kurutac (2008), <http://born.birtherites.org.uk>
Birth: eight women's stories by Nancy Durrell McKenna, www.b-lineproductions.co.uk
Aiming for a Natural Birth: A remarkable Guide to Birth, Light Source Films, www.lightsource.com.au
Orgasmic birth by Debra Pascali Bonaro www.orgasmicbirth.com are just a few.

What cannot be avoided however in ethnography, as in film making, is the philosophical difficulty of perspective. The ethnographer, like the film maker, has to situate her/himself, in journalistic jargon, to 'get an angle'. One cannot pretend to have a God's-eye view of everything from nowhere (Haraway 1996); whether as a first or second-hand observer we will take from a scene whatever has meaning or interest for oneself. This process cannot but be deeply idiosyncratic. I have engaged in this issue not least because it is a principle that pervades epistemology, the theory of knowledge creation, and thus requires constant and visible reflection. The issue of researcher selectivity is also important because I have made some decisions about what not to include in my description of midwifery practise. It may seem peculiarly counterintuitive but I have not described the physical minutiae of midwifery practice. I suspect that most of my audience will be midwives and will know what certain artefacts are and what certain actions mean. For midwives I do not have to describe every little positioning of the hands on the abdomen for the purposes of palpating the baby in the uterus. To the non-midwife however these may be important aspects to spell out. They are ethnographic observations that ought to be documented somewhere, but they do not form part of this ethnography. A single doctoral thesis cannot hope to address all these aspects within its covers.

There is considerable professional expertise inherent in all midwifery actions, but the technical details and even much of the rationale is available in midwifery texts and research articles. As in so much of midwifery, nursing or medical practice, there is however a worrying dearth of empirical evidence to support many practices. What is lacking in such texts, which may become available only through observation and interview, is the meaning that each or any of these actions has for the midwife performing them.

Where I have spelled out specific midwifery activities such as maternal and fetal monitoring, the purpose has been to discuss social theory such as Foucault's (1978) consideration of the power and the techniques of surveillance.

Midwives may be observed and are able to articulate the practice and immediate purpose of monitoring maternal and fetal wellbeing and so I do not need to describe the process. Monitoring and measuring as techniques for objectifying and applying normative limits upon people is a theme within Foucault's discussions of power. Whether or to what

extent this might be the purpose of monitoring within obstetrics in a hospital context needs to be considered as part of a social critique. So too does the degree to which monitoring and surveillance as techniques of power extend into home birth midwifery practice. Other contemporary and midwifery-specific questions about knowledge and authority, such as raised by Davis-Floyd and Sargent (1997) and Jordan (1992, 1998) also present themselves for consideration.

In none of these examples of possible linkages between this ethnography and extant theory, is there a need to describe either the detailed use of the physical artefact, or to explain the biomedical rationale for the measurements recorded. Of course a different ethnography could very easily use such minutiae as the basis for examining participants' interpretations of what is going on and what exactly they think they are doing. The purpose of this ethnography is to paint a broad sociological picture of independent midwifery practice in the contemporary Irish maternity context.

As the underpinning of ethnography is to be as naturalistic as possible, field notes and diaries form the main data source for this study. Formal, digitally recorded, interviews form only part of the data collected but they do provide some verifiable verbatim record of the midwives' own words. Collection of data directly from the independent midwives within their social context was informed by my own experiences of setting up as an independent practitioner in Dublin in 2006. My own discovery of the difficulties and joys of independent practice form another, highly autobiographical, data source in the ethnography.

Autoethnography: Autobiography in ethnography

Autobiography acknowledges the interpersonal in research and indeed can provide the most explicit material for reflexive critique. This section will consider researcher autobiography rather than use of autobiographies, biographical detail or the life-histories of participants.²³

²³ These methods are considered elsewhere by Ellen 1984, du Boulay and Williams 1984, and Reed-Danahay 1997.

The foregrounding of the self in ethnographies has led to a proliferation of subtly nuanced labels or sub-genres of ethnography: auto-ethnography, self-ethnography, insider ethnography, native ethnography, endo-ethnography (Van Maanen 1988, Okley and Callaway 1992, Van Ginkel 1998 and Ellis and Bochner 2003).

In some senses this ethnography is all or any of these. What is slightly different, or what requires adequate philosophical or methodological defence, is the use of the purely autobiographical. An isolated autobiography would not, it would seem, require ethical approval, but could it be presented on its own as doctoral level research? If autobiographical narrative could not stand alone, how could its 'data' or 'findings' be construed as legitimate additional source material to other ethnographic, primarily participant, observation? By the same token however, why and how, could my experiences and viewpoint be ignored? If someone else were to do the same study would my story, my experience not form a legitimate data source?

Many writers have defended the use of autobiography in ethnography (Williams 1990, Morgan and Stanley 1993, Oakley 1992, Birch 1998) and indeed as a research method in itself (Stanley 1992, 1993).

In qualitative research reports, as in part two of this chapter, an autobiographical element is often included. Many writers give a brief biographical outline and summary for their motivation to undertake a given study and leave their autobiography at that. Others more fully position themselves within the text interweaving their experience with those of their informants. Increasingly autobiography appears as a more central theme with writers such as Ellis and Bochner (2003) and Behar (1996) presenting ethnographic works primarily as personal autobiographical writing. This shift has been perhaps most apparent amongst feminist and post positivist writers, in direct opposition to realist and authoritatively objectivist views of 'the other', the observed.

The autobiographical element in this study is not intended simply as a matter of writing style; it is integral as part of the data collection and engagement in the field, that is the life of independent practice. It serves more than just to situate myself at the outset. Certain autobiographical experiences, where I have been observant of my own

participation, not of other independent midwives (IMWs), have revealed aspects of independent midwifery practice that would otherwise have been beyond the immediately observable. My individual perspectives within the area of independent practice may not be 'typical' but then no-one's is. The competing demands of, and motivations for, independent practice and academic endeavour, have been a significant element of my autobiography requiring consideration. I have long considered home birth midwifery as being an example of 'real' midwifery, untrammelled by the demands of institutional throughput and fostering the woman's ability to birth herself. The stability and regular income available from hospital practice and subsequently from midwifery teaching however seduced me. It was the opportunity afforded by funded release from work that allowed me to combine home birth practice and this PhD study. Edwards and Ribbens (1998) write of their experience of juggling the demands of academic endeavour and domestic life. They argue for the legitimacy of using that life experience in reflective autobiography, as it demonstrates the overlap of the public and private spheres so often falsely presented as distinct and separate. To acknowledge the particularity of my experiences, within and alongside those of others, should only add to the description, exploration and, hopefully, understanding of the variety of experiences of being an independent midwife in Ireland in the twenty-first century.

In beginning a new direction in my own personal and professional career, there was a very close interrelationship between data collected for my personal and professional development and the data required for description and exploration of the 'field'. Data presented as part of this study has to have some greater justification than simply supporting a novice practitioner's personal theory about how best to proceed. It has also to allow theory development about that 'field', which is the culture and context of independent midwifery in Ireland. Hammersley (1992:133) emphasises how 'researchers [must] subject results to a higher degree of scepticism'. The culture and context of independent midwifery have to be sufficiently well described and interpreted that they are recognised and better understood not only by participants, but also by academics and health policy decision makers unfamiliar with the scene.

There are at least two significant caveats that would need to be considered in this attempt to integrate autobiography into ethnography. The first is 'going native' which is bound up with losing analytic distance (one can no longer say objectivity). The ethnographer who chooses such a significant degree of participation must be particularly clear about acknowledging allegiances and submitting to a higher order of proof or academic rigour. The principles of being reflexive and keeping an alert ethnographic eye on the experiences would however seem to be applicable equally to autobiography as to ethnographic participant observation.

The second caveat: naval gazing or solipsism in qualitative methodologies, particularly in autobiography, have been countered by many writers (Foley 2002) particularly from a feminist perspective (Oakley 1992, Stanley 1992 and 1993, Wilkins 1993). While tales of the field attempt to establish ethnographic authority by proving one was there (Reed-Danahay 1997, Van Maanen 1998), simply 'proving' one was there is not sufficient. 'Being there' is requisite but not sufficient defence of the interpretations one had made. It seems that the only defence that might be offered is a very open account of my many subjectivities. I offer a rationale for any interpretation which reflects upon the admittedly highly contingent nature of my position in the field, and my relations with the other independent midwives. Simply to say however, 'well that's MY experience' would be to 'hide' in the autobiography. This brings us back to reflexivity, that explicit attention to the influences of the researcher, of my allegiances and analytic processes. This study, in both its ethnographic and autobiographical elements intends to be reflexive and critical. Reflexivity and the social critique attempt to make a link between the micro-social context of my own and other independent midwives' experiences, and the more macro-social context that shape those experiences.

As mentioned above, Van Maanen (1988) identified a range of ethnographic writing typologies. In a similar manner the autobiographical element in ethnography can also be presented as a typology. The autobiographical element may range from the minimal biographical data of a researcher's background, through a middle typology with the inclusion of personal diary excerpts that inform reflexive accounts of the researcher as

observer, to highly autobiographical and emotive accounts of the researcher as participant. This final type, I propose, can be further extended to include cases where there is no 'other'. The researcher is the participant. The autobiography is the observation.

Despite appearances to this point, this ethnography will combine my autobiographical pieces with larger portions of participant observation and interview where I attempt to capture other midwives' descriptions and explanations of their experience.

Section Four Analysis and trustworthiness

An exercise in the rhetoric of analytical rigour

Hammersley (1990, 1992) asserts that research requires a higher standard of proof than passing observation or appeal to everyday common sense. Lincoln and Guba (1985) use the term trustworthiness to describe rigour in qualitative research. Oakley (2000) and Robson (1993) each brought together the writings of several authors to identify the central requirements of trustworthiness in research. They identified that there must be clarity about the sample, and the methods of data collection. There is also a requirement to demonstrate ethical behaviour throughout the research. Furthermore the methods and methodology should be consistent with the philosophical perspective that places the study or piece of work within philosophical and epistemological schools of thought. These procedures each make explicit to external observers the attention given to the research process, so that the reader can then determine the fittingness to their own situation. In summary then, rigour 'is associated with openness, scrupulous adherence to philosophical perspective, thoroughness in collecting data and consideration of all data in the subjective theory development stage'(Burns and Grove 1999:372).

For those who have some familiarity with midwifery, or home birth, or community practice, there is a (hoped for) possibility of recognition, of the story of this ethnography 'ringing true'. For those unfamiliar with the topic area, or disinclined to base their judgment of a piece on its 'plausibility' however, researchers feel (I feel) the need to demonstrate and defend how the 'results' are drawn from the data.

The demonstration or audit of the moment of conceptualisation in interpretive analysis is very difficult. Thomas and James (2006) point out that even grounded theory's rigid

analytic procedurality fails to capture, and can even stifle, the essentially creative and idiosyncratic moment of insight. The point of creative conceptualisation, even in the sciences, is difficult to demonstrate. The creative moment in the putatively objective sciences is not in the procedurality of the ‘proof’ but rather in the inspiration for the question. From whence came the question?

I am not testing something that requires proof so I resist the temptation to demonstrate the rigour required of a proof. I am telling a story, and asking questions that occur to me as I proceed. I can offer no more rigorous proof than to submit this story as evidence to my claim that I was there. As I tell my story I will offer some small evidence that demonstrates (to me) that my ideas were founded in what I saw. I offer only my own concern about the possibility that I may be ‘suited myself’ in the examples I choose. Without my raw notes you cannot know that I have not ‘doctored’ the evidence I supply, and even with them, you could only possibly verify that my view and my version is partial. I acknowledge that already.

This however is a doctoral thesis and I must endeavour to demonstrate a grasp of, indeed a facility in the language of knowledge creation. I offer the following trawl through potential analytical methods proffered by methodologists as means to securing analytic rigour, remembering that even if this story were entirely ‘fiction’, one might still learn (something) from it.

Analysis

Thematic analysis (TA) and constant comparative analysis (CCA) are terms used to describe the analytic process. They describe methods for the synthesis of theory or abstraction from the ‘lysed’ or broken down data.

Data coding is the initial process of organising data at the most descriptive level. It is a means of data reduction. This apparently simple coding or categorisation requires some imaginative grasp of similar or related terms and recognition of pattern. It can be demonstrated (and thus audited) either by exemplars or by the presentation of all the data in its initial codes.

Thematic analysis (TA) is essentially a reversal of this coding process. Using the same interpretive skills of pattern recognition and imagination, the data is reconstructed; not simply back into its massive and complex raw form, but instead into a range of more abstract themes that provide an explanatory order to the disparate categories identified at coding. Again this imaginative step can be made available through exemplars or presentation of all the coded data within the putatively explanatory themes. Being able to audit the steps of coding and the subsequent abstraction into themes allows the reader to verify those themes, to confirm or deny that such abstraction was legitimately done.

Constant comparative analysis (CCA) does not wait until all the data is gathered to reconstruct abstract organising themes. Instead it uses the initial codes (concepts) from early interviews or observations, and tentative but explicit theory about the relationship between concepts as the basis for ongoing and focused investigation of the topic of concern. In prolonged exposure to the study field or in multiple case studies, a degree of comparison by the researcher between events and cases is inevitable and useful in developing themes and theoretical connections between them. This ethnography is a result then of both TA and CCA. Unlike grounded theory however, which makes explicit the micro-theories throughout, and aims to derive a substantive theory as its end product, this is ethnography, and does neither.

Analytic breakdown is a step towards synthesis which is rearrangement and clumping together of codes into larger related concepts or themes. This is again an interpretive process and the essence of interpretive research 'findings' is the justification for that organisation and reorganisation (Robson 1993). Interpretation is personal and idiosyncratic; the same data might support several interpretations. The researcher should, and I will, attempt to give exemplars as signposts of concept development and provide rationale for their putative relationships. Justification and rationale are part of the narrative process of ethnography. A summary of the main thematic codings will appear in the appendices with examples not directly appearing in the main text cited there. The bracketed annotations in the form (page, line, source and date, eg. p19L10 Diary

28Aug08) allow verification of the grounds for the claims made in the text. This is the means by which the analysis, codes and themes in this study can be audited.

An in-a-nutshell summary of this ethnography could be presented as a consideration of the themes of birthing autonomy and professionalism and the tension between them. The organising structure of the ethnography into these thematic areas is not however the final intent. Ethnography, as has been mentioned in section three of this chapter, is more about unfolding the story and the experiences of the actors in the scene. The thematic organisational structure is almost incidental. The themes are arbitrarily utilitarian, other structurings might have been used to tell the story; the intent has not been to identify definitive essences or core concepts within independent midwifery experience.

There are several other processes which, despite not being explicitly auditable, further enhance the analytic rigour of this study. They are consideration of counter instances, reflexivity and member checking.

Counter-instances

When considering the development of themes or concepts it is good analytic practice to test them against counter instances. Polit, Beck and Hungler (2001:314) call this searching for disconfirming evidence, and Robson (1993:380) refers to this process as negative case analysis. Openness to refutation refines concepts and strengthens their overall utility. The potential for falsification of theory is the basis for the scientific method and is considered more explicitly by Gary Rolfe (2000) and Thomas Kuhn (1962, 1977). In this study therefore when examining the rhetoric and practice of independent midwives in relation to concepts such as autonomy and professionalism, real or apparent counter-examples are examined to provide a more complete picture, and to capture the variety of their perspectives.

Reflexivity

Many authors have considered the dual nature of participant observation (PO). PO is most often represented not just as observation of participants, but considers the

researcher's role within the setting. The researcher can be positioned anywhere within a range from complete participant to complete observer. A willingness to embrace the inter-subjective and multiple realities of social actors which is the basis of interpretive research methods, expands to include the subjectivity of the researcher. Consideration of the position of the observer, both as observer and participant, and the degree to which one is either, or both, forms a starting point for reflective analysis of how one interacts with the observed. Reflexivity is the attempt to acknowledge and identify the researcher's subjectivity, reactivity or influence within the field, and has been cited as a key analytical tool for enhancing the critical power of qualitative work (Stanley 1993), and leads to what Sandra Harding (1987, 1996) calls 'strong objectivity'.

Field notes and research diaries can provide material for reflexive writing. Often however, this material does not appear in final written studies or ethnographies. Analysis of the reactivity and the subjectivity of the researcher / ethnographer has long been the subject of ethnographic writings. Van Maanen (1988), in his consideration of ethnographic writing styles, acknowledges the move from early, seemingly realist and objective ethnographies of non-western societies, to a greater appreciation and justification, indeed requirement, for the presence of the researcher within the text. Davora Yanov (2008) argues that the absence of authors' values in 'classical anthropology' disguises the colonialist, sexist and classist assumptions that often underpinned their analyses. This consideration of the positionality of the researcher led to Judith Okley's (1994) description of ethnographers as 'positioned subjects'. The presence of the researcher within the ethnographic text is therefore at least autobiographical; the text is not usually explicitly an autobiography as is partly the case in this study. The keys to reflexive writing, which I am aiming for in this ethnography, are balance and transparency.

Member checking

If, as I have argued the outcome of analysis is essentially my own creation and my interpretation only, then offering it to others for verification seems pointless and logically inconsistent. Member checking, or participant verification, has been criticised as an

inadequate as a demonstration of trustworthiness. It is susceptible to people liking the positive things written about them but disliking the negative which promotes hagiography rather than critique (Holy 1984) and thus may not necessarily be a good check of validity (Silverman 1985). Such a stance however is cynical and objectifies the researched by dismissing and devaluing their subjectivity. Seeking feedback and engagement with the outcomes of the research, is more than just member checking, where silence could be misconstrued as assent. Instead it recognises that members can confirm or deny the veracity of the analysis but furthermore positively contribute to the critique of their own situation. The principles of respect and reciprocity in the research method demand that I do not co-opt the midwives' voices to my own purposes. As will be discussed in the next part on feminist perspectives, the midwives must be given some control over their circumstances and the products arising from their engagement in the study.

Ultimately, each midwife within the study has an insight to the experience of being a midwife in twenty-first century Ireland to which no other is privileged. Trustworthiness is demonstrable at many levels. The most difficult to demonstrate, and thus to audit, is the process of ideation; even clearly audited, interpretations can still be wrong. The people I trust to tell me whether I have interpreted the independent midwifery experience are independent midwives. If they can recognise and engage with what I have written, even if they might not agree with it in total, then I will feel I have succeeded in no small way.

Section Five Feminist perspectives in a critical ethnography: from micro descriptive to a macro theoretical analysis

The basis for reflection and the social critique embedded in this ethnography is a generally feminist perspective. Feminism and postmodernism have challenged the dominance and legitimacy of the philosophies of modernism, scientific rationality and logical positivism. These philosophies underpin the application of the experimental and statistical methods of the natural sciences and can assume uncritically that they can be applied to the study of the human as object. They are not necessarily appropriate to the study of, and knowledge creation about, the subjective experience of people (Stanley 1992, Rosser 1992).

The quantitative scientific methodologies typical of obstetrics, and, Wilkins (1993) would argue, also midwifery, work from a professional rather than a personal paradigm. Quantitative methodologies strive for objectivity over subjectivity, in so doing they devalue individual experience and the importance of context and relations that are so important to individual experience (Harding 1987, Rosser 1992, Belenky et al. 1997). Feminist writers in the field of reproduction and childbirth such as Murphy-Lawless (1998), Martin (2001) and Edwards (2005) and many others have written at length on the effect of this way of thinking has on creating knowledge about women and about childbirth. Women, these authors argue, are objectified, and embodied knowledge is disregarded. The pervasive mechanistic language of such discourses are employed to control women and birth. To abuse Susan Orbach's (1998) construction, Birth is a feminist issue. In the words of Jean Donnison (1988)

‘it is women, and only woman, who must carry and give birth to children ... childbirth still remains, in the last analysis, ‘women’s business’ (Donnison 1988:201)

There is no one feminism but a whole array of perspectives, each with its own philosophical strengths and weaknesses (Harding 1987, 1996, Stanley and Wise 1990). Feminisms range from a radical feminism that asserts an essential female standpoint (Irigaray 1993), to liberal feminism with its appeal to equality, to postmodern feminism which strives to deconstruct the grand narratives of gender (Butler 1990). All of these have been considered by other authors (Bowles and Duelli Klein 1983, Ardener 1993, Garry and Pearsall 1996, Fox Keller and Lonigo 1996, Salih 2004, Davies and Gannon 2005) and I will not attempt to paraphrase them here.

Feminisms have some sympathy with a relativist philosophy that holds that there is no absolute truth but that truth may differ for each individual or culture (Fox Keller and Lonigo 1996, Haraway 1996). While this may prove problematic in that it may be argued that relativism is a self-defeating philosophy, as internal consistency requires that it recognise itself as only ‘a’ version of truth not ‘the’ truth; it does begin to open up a discourse whereby the hegemony of scientific rationalism can be recognised and challenged.

Awareness of the subjective

In my relations with the midwives in this study I have not tried to maintain an objectifying distance between myself and the other midwives. Rather than being formal interviews, my conversations (Oakley 1990) have been more reciprocal with sharing of my situation and, as invited, my opinion. I have not attempted to hide myself as author but acknowledge my own subjective presence in the writing and explicitly in autobiographical elements. At the data-collection stage, transcripts of any digitally recorded conversations (and in some cases interview notes) were made available to the midwives. At the analysis stage I have offered the other midwives my ongoing analysis and at two stages sent them drafts of my writing. The first drafts sent were about the day-to-day logistics of midwifery work, and the second about the dilemmas of trying to balance relational and professional demands. Ultimately however this work is my interpretation of their stories and experiences. I have tried to be as transparent as possible about my intentions and activities and I have invited and encouraged their engagement in the forming and interpretation of the ethnography. In relation to my own engagement in the field of independent midwifery, I have again avoided objective distance and have participated in lobbying, liaison and committee work which is in keeping with the philosophy that the personal is political, and that actions speak louder (of my commitment to midwifery) than words.

The examination of the day-to-day

It is in the examination or explication of the day to day that feminist research counteracts the tendency, in patriarchal research, to ignore the everyday ordinariness of human (women's) experience. It is ignored in a two-fold manner. Emphasis on the abstract means the particularity of the subject's (woman's) experience is lost. Furthermore patriarchal research tends also to emphasise the public sphere, which reifies objectification, abstraction and generalisation, and leaves the private sphere, unseen and undervalued. It is this unseen and undervalued domestic or 'women's work' which props

up and enables the workings of the public (or civil) sphere (Pateman 1988). Dorothy Smith (1987) therefore argues (as do others including Mies 1983, Stanley and Wise 1993) that the use of the everyday of women's experience is the crucial starting point for any critical feminist research. The argument is that such silencing needs to be countered. Starting with women's experience and then articulating that experience within its very specific context, demonstrates the direct interface between individual (subjective) experience and broader theoretical models of social structures.

An emancipatory vision

The creation of knowledge for the purposes of emancipation, as is exemplified in feminist theory (Lather 1991), is an epistemological position which would appear to be appropriate to the study of all aspects of midwifery and childbirth practices. Feminist sociologies of childbirth have been written by Murphy-Lawless (1998) and Edwards (2005) and it is upon these that this study has been modelled. Zygmunt Bauman (1993) however critiques modernity with its grand narrative of progress, which includes the emancipatory ideal. He describes modernity's promise of inexorable progress as illusory and as failing to recognise that each putative progress brings with it consequent problems and dilemmas. He argues that a postmodern questioning of such grand narrative demonstrates all too clearly the shortcomings of the modernist vision. Bauman disputes the emancipatory vision but does not slip into futile relativism. Instead, he and other commentators on contemporary society, describe late modernity as reflexive, that is self-aware. Reflexive modernity acknowledges and is concerned at the often negative consequences of its own putative advances (Beck, Giddens and Lash 1994). A feminist emancipatory perspective engages in an examination of the power relationships at play in any given setting. As Wendy Brown (1997, 2001) says, it is difficult to defend an exclusively feminist purview on power, as power relationships pervade much more than sex or gender relations. Class, race, sexuality and differential physical or mental ability are all relevant considerations in the examination of social dynamics. Nonetheless, for me, an emancipatory vision and consideration of the patriarchal structures of contemporary maternity services bear the potential for a fruitful critique.

Foucault and knowledge as a mechanism of power

There are aspects of Foucauldian thought that might serve to frame critical analysis of independent midwifery. They are his consideration of knowledge / power and, derived from this conjunction, his ideas of surveillance, normativisation and the disciplining of 'docile bodies'. Furthermore, his conception of discrete, internally coherent epistemes, offers the chance to critique the current dominant episteme which is scientific rationality.

Foucault, in 'Discipline and Punish' (1978) introduces the linked concepts or the conceptual binary which is power/knowledge. Although Foucault drew heavily on the links between power and knowledge he never actually said, what has been widely held since, that 'knowledge is power'. The two are not synonymous. Knowledge about something does however give the knower quite a considerable degree of power. To be able to describe brings understanding, and then possibly the ability to manipulate that which is known. Knowledge of something is the basis for the operation of power over it. Foucault goes to great lengths in 'Discipline and Punish', to describe the processes, or what he calls the 'techniques' of power. The basic technique is surveillance, which is the observation and detailed measurement of phenomena and of individuals.

Information derived from surveillance methods, allows population distribution norms to be identified and allows individuals to be placed on a continuum. As natural variance is described graphically, it appears as a 'normal' distribution curve with its 'bulge' in the middle and fewer individuals at the extremes of the range. The simple awareness of this surveillance information, that there are 'norms' however has a normativising effect. Normativisation is the ascription of values to the normal, the more common or usual; the extremes can be valued as better, or worse, than each other. Thus the use of surveillance data then becomes not just descriptive but normative.

As Richard Rorty (1982:195) puts it;

'whatever terms are used to describe human beings become 'evaluative' terms'

The examination of the body and the itemising of human activities and use of time, enables further ordering, controlling or in Foucault's word 'disciplining' of the human

body. Foucault's description of 'docile bodies' applied originally to the control of soldiers' bodies, but it also captured the disciplining of the human person in education and manufacturing processes. Foucault (1978) proposes that discourses about the body have promoted subjugation of the individual and control of the population. The disciplining of 'docile bodies' very clearly applies to the uses of medical surveillance and knowledge of the human body. This epistemological junction of the body, power, medicine and reproduction is of particular relevance to knowledge creation about childbirth and childbirth practices.

Foucault's earlier book 'The Birth of the Clinic' (1973) describes the rise of medicine as a social force in France. Medicine harnessed the techniques of observation, measurement, examination, mathematics and experimentation in its acquisition of knowledge. These techniques are the methods of science. Scientific enquiry has become the basis for rational decision making and forms the basis for medicine's claims to authority to speak about the human body. Scientific enquiry is the knowledge base upon which the power of medicine is built. Science however is abused when its claimed descriptive objectivity is co-opted, by the process of normativisation, into evaluative statements about what is good and bad.²⁴

Foucault and Feminism a fruitful partnership for social critique?

Epistemology is the theory of knowledge. Foucault (1978, 1980) argues and demonstrates that there is no universal, eternal or correct 'way of knowing' but rather that knowledge systems (epistemes), while internally coherent for a period, are subject to change. At present and for some time, the dominant claim to know anything has been based upon the methods of science. Epistemic authority describes the power and status that come with the claim to knowledge. Scientific 'evidence' is the currency of knowledge power in contemporary society. The techniques of power, and the disciplines, which Foucault

²⁴ That nursing and midwifery academia have so wholeheartedly embraced the scientific method is a concern. Alternative epistemologies, and the production of graduates with the intellectual capacity to engage with them, are essential for social resistance. By this I mean resistance to the fixation with scientific evidence that diminishes other human knowledges including, particularly, a resilient personal morality.

describes and which underpin the scientific method, are not uncontested in contemporary epistemology. In his own words:

‘At the heart of the procedures of discipline, [] manifests the subjection of those who are perceived as objects and the objectification of those who are subjected.’
(Foucault 1978:184-185)

Scientific objectivity has been challenged by feminist and postmodern epistemologies. Subjective knowledges heretofore rejected by the scientific rationality of medicine are beginning to inform midwifery thinking. A counter discourse is emerging that challenges medicine’s privileging of objectivist knowledge and the lure of increasing technological intervention in human activities (Balshem 1993, Becker 1998, Murphy-Lawless 1998, Davis-Floyd and Mather 2002).²⁵

Foucauldian theories and writings would therefore seem to overlap with a feminist perspective. Sawicki (1991), McNay (1992), Cain (1993), Ramaznagolou (1993) and Soper (1993) all discuss the possibilities of combining Foucauldian analysis of power and a feminist social critique. In this ethnography the combination provides a basis for understanding and analysing the relationships, both micro and macro, that form the culture and context within which independent midwives provide home birth support.

So far in this chapter then I have discussed the very open nature of the research question which is not inconsistent with ethnographic studies. I have given some biographical background of myself as the primary data collection tool. Ethnography and autobiography have been described and are considered appropriate methodologies. These methodologies and their methods fit with an interpretation of social reality that has been called social constructionism. Rather than assuming that social phenomena ‘just are’, Berger and Luckman (1966) who coined the term social constructionism, strove to uncover the processes by which social actors (individuals and groups) construct,

²⁵ On top of this counter discourse from outside, there is a momentum from within the scientific paradigm to use ‘evidence’ as a basis from which to contest the many blind spots in maternity (and broader health) practices that are not, and never have been, based upon substantive evidence. Evidence based practice has become a key phrase and concept within health and other professional practice, acknowledging that evidence is not the sole purview of the dominant profession but available to all, including the service user.

influence or perpetuate that reality. My philosophical perspective is that we both construct and are constructed by the society (social groups) we inhabit. This extends to epistemology, the theories held about knowledge and how it is socially created and applied. My intent is to write a critical ethnography, one that examines both the micro and macro sociological relations of power. Feminist and Foucauldian frameworks form the foundation for that critique.

Before moving on to the real applied methods, and the persons, places and practical gathering of data, I wish to consider some ethical principles that apply specifically to ethnography and to this study.

Section Six Ethical issues

Research involving human subjects must respect the dignity of those subjects. Procedures for ethical conduct in research are contained within the Helsinki declaration (World Medical Association 2008) which informs the Trinity College Dublin Faculty of Health Sciences Health Research Ethics Committee. Approval for the proposed research was sought and obtained from that committee. The main principle involved in this study is that of informed consent. Informed consent is part of the principle of autonomy where the moral human subject, when in possession of all the relevant information, is in a position freely to choose a course of action. This principle is discussed further within this thesis where a finer grained consideration of context and relational concerns within the principle of consent is discussed. Consent was sought from the midwife to be observed, with separate consent when interviews were recorded. As observation took place in the context of working with women in pregnancy, labour or the postnatal period, separate consent from the woman was sought. This was to allow me to be present and to observe the midwife's activities during her visits with the woman. While the mother's clinical details, physical environment and interactions with the mother all form part of the context and even content of observations they would neither be the main focus nor form part of the data proper. Consent for these three aspects of the study, midwife observation, recorded interview and access to the mother's home was written. Information sheets about the study and the consent form are included in appendix three.

Some forms of interpretive research are based upon single interviews or one-off interactions. Ethnography, with its element of prolonged engagement in the very dynamic and social setting, must consider how this affects the nature of informed consent. A single, even written, consent to be observed, cannot be assumed to apply for the rest of one's life. Consent is therefore, to an extent, time limited. Usually for example, this is for the period of the one hour interview. Ethnographic observation can take place over a period of hours, days and even, in some cases, years. Consent is also limited somewhat to context. Consent to be observed at work may reasonably overlap with work in the home, but might not reasonably overlap with other aspects of one's life, one's sex-life, dietary habits or recreational activities. Of course any or all of these may explicitly be what the ethnographer wants to observe, and may thus be consented to, but even then, the observed may choose to withhold consent at certain times or in certain circumstances that they do not have to explain. Thus the principle of ongoing consent has to be adopted. This gives maximal flexibility to both the observed and the observer that allows for the complexity and dynamic nature of the naturalistic social setting, and for the individual vagaries of human existence. The challenge then is that the ethical decision to include or not include certain observations depends, in the first instance, upon the researcher reading the situation, the implied consent or withdrawal of it at any point and throughout the study. Secondly, it requires the researcher taking an ethical stance not to use data available in those 'unguarded moments' as to do so would be an abuse of the generosity and good will that allows them to be present. The problem with research ethics committees is that they cannot cover all the possible complexities of any study, particularly perhaps longitudinal human interpretive ones. Ethical research therefore relies on a certain moral and ethical uprightness on the part of the researcher. Research ethics committees' concern with the protection of the research subject can become so paternalistic that layers of red tape and requirement of signed consent forms for every eventuality could severely inhibit not only flexibility of design but also participation in, 'real world' research (Robson 1993).

The ongoing nature of ethnographic observation is therefore problematic but not insoluble if a flexible and engaged (reflective) ethical stance is supported. A further contextual problem characteristic of ethnographic studies is that of the consent of third

parties passing through the observation field. The primary participants in the ethnographic field will know (and hopefully consent) that the observer is observing and presumably recording (somehow) the 'goings on'. Other social actors who interact with those primary participants may not know and therefore cannot consent to participation. Alternatively, they may know or come to know of the research and definitely withhold consent to become part of that research data by being recorded. They may (but only if they are aware) even explicitly refuse to be observed by demanding withdrawal of the researcher. Again, to cover all these eventualities and to request explicit consent (which requires explicit explanation and possibly even written information) of every passing, potential opportunity for observation, would so stifle the intent of 'naturalistic' observation, as to make it impossible. Again too, the researcher must attempt to read the situation and gauge who must reasonably be given information and asked for consent, and for what. The researcher requesting such flexibility and broad remit in their research as I am proposing here, must strive to demonstrate their ethical bona fides by addressing these very issues as a reflective researcher. They (I) should identify likely instances where others' involvement should be reasonably catered for (in this case the mothers). Furthermore, they (I) must make clear, where there is any doubt that inclusion of a detail might compromise another person's anonymity or reputation, that it cannot become part of the research data or report. We are all daily subject to the observation of others. To an extent we all reflect upon or judge what we see. Those of us attempting to make epistemic claims based on those observations should at least consider the ethical consequences of so doing.

Section Seven Research theory into practice

Clarification of the term 'independent midwife'

Practicing midwifery outside the more usual context of hospital is the defining characteristic of the midwives comprising this ethnography. There are some instances in Ireland of a home birth service offered by midwives who are employed in and by a maternity hospital. Particularly notable are those in the integrated scheme in the South East region, Waterford and Wexford, and the DOMINO and home birth scheme in the National Maternity Hospital Dublin. These schemes however are both geographically and

numerically limited and account for only a small proportion of the home births in Ireland. Crucially different too is the fact that midwives working in those settings fall within the control and management of the hospital structures, policies and guidelines. These factors can reasonably be expected to radically effect and differentiate their practice and experience. Their experience does not form part of this ethnography but if home birth as a choice of place of birth is to be seriously embraced in Ireland, such models may be one way of making home birth more widely available. Research into midwives' as well as women's experience of these hospital satellite models would need to be considered.

The need for clarity in definition of terms requires more than a simple description of the midwives in the ethnography as home birth midwives. Their practice is domiciliary, that is, in the home. Sometimes such practice is more loosely labelled as 'care in the community' or part of 'primary health' care. Independent midwifery falls within all these descriptions. Again however there are some other midwives who work in the community or domiciliary setting but who do not do home births for example midwives working in early transfer home schemes or with general practitioners who share antenatal care with hospitals. There are also some Public Health Nurses (PHNs) who are registered midwives and run antenatal and classes or breast feeding support groups and baby clinics. These practices are localised and isolated rather than widely or nationally available and form a discrete part of those midwives' work rather than the major part. The midwives I am writing about are independent of the hospital maternity services and so I have called them independent midwives (IMWs). It should be noted however that even this title is contentious as the idea of independence while having associated positive attributes, also has separatist connotations with overtones of 'maverick', unmarked, unregulated, and not quite acceptable. In the most recent Health Services Executive (HSE) report on domiciliary midwifery (Domiciliary Birth Implementation Group, HSE 2008) the denomination self-employed community midwife or SECM has been used. It is indeed the self-employed status that defines and differentiates the midwives in this study. I have however consciously continued to use the term independent midwife rather than SECM or domiciliary midwife as it allows the contested nature of the concept of their independence to linger in the mind.

Methods in practice and in context

Over a period from May 2006 until January 2009 I spent periods of time observing the work of independent midwifery practitioners. Although the work permeates all aspects of their personal and domestic lives, some of which I was invited to share as a colleague and as a researcher, my observation focused on them while they delivered care either in their own homes, or in those of the women they attended. I was able, mostly during travel between ante and postnatal visits, to talk closely with them about their relationships with the women, about their clinical decision making, and about how their midwifery practice impacts upon the rest of their lives. As the working relationship between mother and midwife is periodic and not constant, I had to arrange to be with the midwives at times to their and their clients' convenience. My presence as an observer undoubtedly would have been somewhat intrusive and might have effected that which was observed, the women and midwives were free to select times when they felt my presence would be least disturbing.

All aspects of my personal biography and personality are likely to have reactive effects in my relations with the midwives, women and other actors within the ethnography. The fact that I am there as a researcher, and that I am a midwife, a midwife teacher and a gay man, cannot but have a bearing on what I see, what I might be shown or told, and how I interpret the social setting. I am a male midwife (or a midwife who is male) and the rarity of this combination raises questions for many. Walsh (2009) discusses how being a man can impinge on midwifery practice, and his view that his gender does not detract from his ability to relate warmly and effectively with women and midwifery colleagues, reflects my own. I cannot be other than a male and benefit, or suffer from gendered effects on my social relationships, either as midwife or as researcher. Some of my biographical history, such as my midwifery experience or being gay, I can choose to bring to the fore or suppress in the course of my dealings with others. My maleness I cannot deny; I can only strive to be aware of, and thus hope to diminish, the more manifest expressions of patriarchy evident in even everyday human interaction.

The feminist principle of reciprocity, engagement, and acknowledgement of the inter-subjectivity of researcher and researched informed my practice (Harding 1987, Rosser 1992, Stanley and Wise 1990). Therefore, as mentioned above, I engaged in the conversations (Oakley 1990) as openly and honestly as seemed appropriate and answered questions about my own practice, situation and opinion whenever these were asked for. As part of the ethnography, indeed because of the freedom given by the funding awarded by the Health Research Board to carry out the research, I was able to engage in independent midwifery practice myself. Thus I was able draw upon my own independent practice experiences, to open up issues and insights of which I might not otherwise have been aware had I been a non participant. My research diaries therefore contain elements of autobiography as well as a record of the ethnography proper. I also kept notes and memos on my reading around the theory and writings of midwives, sociologists and others interested in the fields of reproduction, home birth, and midwifery. As part of my personal journey toward independent practice, I became more engaged in various organisations and communities that helped inform the ethnography by providing other sources of information and context upon which to build a fuller ethnographic picture. These included participation in the midwives' section of the INO, contact with other midwives through the Irish midwifery e-group, email contact with other independent midwives, participation in the Domiciliary Birth Implementation Group (DBIG) of the HSE. I also worked in collaboration with midwives (independent and hospital based) in responses to proposed legislation on nurse midwifery prescription, and on amendments to the Nurses Act / proposed new Nurses and Midwives Act. I was able to meet with the coordinators of the Cork home birth scheme and attend one of their collaborative support group meetings. I have attended Home Birth Association (HBA) annual general meeting and conference days and also meetings of AIMS (Association for Improvement in Maternity Services - Ireland) all of which were attended by one or more independent midwives and provide something of a professional and social support to home birth midwives. Although I have not included the experience of hospital-based home birth midwives, except where it is drawn from the independent midwives' own history and experience, I have also spoken with many midwives based in hospital or who offer DOMINO or home birth through their employing institution. In the latter year of the

period the independent midwives (and I as one) began the process of setting up an organisation for professional peer support for independent midwives called the Community Midwifery Association (CMA).

The ethnography is therefore informed by a variety of data sources, not least by my becoming embedded in the world and context of home birth support in Ireland. While formal digital recorded interview is somewhat incongruous in a naturalistic approach such as ethnography, I did ask if the midwives would be willing to record their views and opinions about home birth and independent midwifery practice. Many did, and transcripts of those usually quite informal interviews allow me to add some verbatim quotes where appropriate to other field-note-based records of their behaviours and explanatory narratives.²⁶

Participants

To try to summarise the amount of material, the observations, experiences and interviews becomes, perhaps necessarily, somewhat quantitative; but such a summary gives a basis upon which to judge my larger narrative. At any one time over the period there were approximately fifteen midwives offering home birth support outside hospital derived services. I observed and / or interviewed eighteen of twenty-one midwives who were working in the period plus a further three who had stopped practicing in the previous few years. I directly observed eleven of the midwives giving care to seventy-six women antenatally, in labour, and postnatally. The majority were antenatal visits and included only five women receiving in-labour care and giving birth. Five midwives stopped practicing (moved away or retired) during the period and three (including myself) started independent practice. Three more have expressed an interest in doing home birth and have made approaches to the HSE and to the newly formed Community Midwives Association (CMA) but have yet to attend their first independent home birth.

²⁶ Throughout the text supporting data sources are included in the following notation:
(page, line, source type, day month year) eg p37L29 FN 12Aug08
Source types are Diary - D, Field Notes – FN, and Interview – Int.

I booked seventeen women for planned home birth and provided only postnatal care to a further three women. Of the seventeen (ten prims, seven multips),²⁷ twelve had home births and five (all primiparous) transferred to hospital care in labour. Three doulas, one student midwife and two midwives attended with me at various of these births. I was contacted by seventy-five women who were seeking a midwife to provide home birth but I was unable to accommodate them. Most of them had also contacted the other midwives in the Dublin area; I do not know how many found a midwife to attend them at home.

The midwives – some demographic details

The independent midwives in Ireland are a diverse group, ranging in age from their 30s to their 70s. They are single, married, divorced, separated or living with their partners. They are, with the exception of myself who is male and gay, women and, I assume, straight. Some have no children, some (recently) have new babies, some of school age and some with older children who have left home, some are grandmothers. Some live alone and some have other dependent relatives, requiring care, living with them. Some live in large urban cities, some ‘out in the sticks’ in rural isolation. Almost without exception they have cars (I am the exception), mobile phones and land lines, and nearly all would seem to have access to the internet and e-mail.

All the independent midwives are formally educated, ABA-registered midwives. Most have a nursing qualification (diploma, over three years) followed by a further 18 month or two year midwifery education (with academic awards varying from certificate to post graduate diploma). One has a four year midwifery degree without a nursing qualification. Several (6+) have Masters degrees in midwifery, nursing, women’s studies or in allied health or sociology fields.²⁸

²⁷ Prim is midwifery vernacular for primigravid or primiparous, that is first time pregnant or having had her first baby. Multip similarly means multigravid or multiparous, that is pregnant having already had one or more babies

²⁸ In the spirit of feminist emancipation and reciprocity alluded to in this chapter, and to demonstrate that the independent midwives are more than research subjects but rather are proactive practitioners, appendix two details some of their post graduate academic achievements, their research publications and their engaged home birth and midwifery praxis.

Most have worked as nurses and / or as midwives overseas, in the UK, USA, Australia or New Zealand and several have worked in developing countries. All have trained in large maternity hospital settings, most with some exposure to community / domiciliary midwifery practice as part of that training or post qualification. They bring this wide range of experience back to community midwifery practice in Ireland. Some work part or full-time as community nurses or as public health nurses or as midwives in maternity hospitals. Several work full or part-time in midwifery education or pre nursing college. Many more have given talks or lectures to midwifery or other student groups about health, pregnancy, midwifery or home birth practice.

Summary

This chapter has considered ethnography, and the validity of autobiography as an integral part of ethnography. It has justified ethnography as the most appropriate method for exploring the broad issue of independent midwifery experience.

A Foucauldian feminist perspective has been briefly outlined as offering a framework for the ethnographic description, for social critique and for the possible development of theory. An initial autobiography has been offered to give a sense of my perspective as the main research tool. The chapter also described the sources and practicalities of data collection. In the spirit of emancipation, respect and reciprocity which underpins engaged feminist research praxis, a list of the research publications produced by the independent midwives is appended to this thesis. It demonstrates the considerable power and proactivity of this group in their continued political engagement in midwifery politics and birth activism in Ireland.

Chapter Three The day-to-day of independent midwifery

This chapter is presented in several contrasting but complementary parts. Each considers the day-to-day and ordinary practices that constitute independent midwifery in Ireland. The first is a consideration of the unpredictable and socially embedded nature of birth. The variability and the communality of birth are significant in the experiences of both mother and midwife and are the context within which they relate. The next section of this chapter examines the logistical issues which must be faced in order for a midwife to facilitate a woman's decision to birth at home. Issues such as being on call and the distances the midwife has to travel to women's home are considerations that derive from, and speak to the concepts raised in the first section, birth's unpredictability and its embeddedness in community experience. The third section takes a different approach to this ethnography of independent home birth midwifery. Having outlined some of the logistical concerns in section two, you the reader are asked to imagine integrating pregnancy and birth's unpredictable nature into your own day to day. This is a device intended to evoke something of the complexity and personally demanding nature of domiciliary midwifery work. It will demonstrate that there is more to independent midwifery than simply juggling one's personal and professional or work life. There are also complex decisions and difficult dilemmas that must be negotiated even in the ordinariness of the midwife's day to day. The dilemmas form a major part of the thesis and are addressed in subsequent chapters. This chapter closes with a section entitled 'starting out' which is largely autobiographical. In it I describe my own journey towards independent midwifery practice. Most of the midwives I spoke with have been practicing for many years and so their concerns were somewhat different from those of a novice setting out. This section describes the hurdles that must be overcome when setting up but also considers the first contact between mother and midwife, an aspect of the independent midwife's experience that was not easily amenable to direct participant observation.

Section One Birth, variable and communal

This section is an attempt to recognise and value the ordinariness of daily life, and to keep it as the basis upon which to build or link analytic theory. This is a project consistent with a feminist perspective that recognises how women's lives and voices may

become lost in the description and analyses of others (Smith 1987). Smith argues that the everyday work of women in mediating (supporting, maintaining) social or patriarchal structures is unseen, 'their experience as subjects has been excluded.' (Smith 1987:97) and is therefore un-theorised. She proposes that examination of the relation between subjective experience and social structures does not require generalisation and abstraction, and that it need simply describe social organisation.

'We begin from where we are. The ethnographic process of enquiry is one of exploring further into those social, political, and economic processes that organize and determine the actual bases of experience of those whose side we have taken.' (Smith 1987:177).

Every person, every woman, every midwife exists within a very particular set of personal, family and social circumstances. Who we are, and how we see ourselves, is not only influenced but largely constructed by the society and the culture in which we grow. By the same token, and to counter allegations of determinism, we influence our society, our culture and community, by our own actions, will, agency and ability to accept or challenge social norms. This constructionist (Berger and Luckman 1966) and relational (Mackenzie and Stoljar 2000) philosophy underpins my interpretation of the lives, motivations and rhetoric of independent midwives. A feminist acknowledgement of the differentiation and interconnection between public and private spheres (Pateman 1988, Smith 1987) further explains my attempt to focus on, and analyse the day to day context of their work. The practice of home birth and midwifery work must engage with the dominant model of hospitalised birth. This is especially so at the interface between the two models when transferring from planned home birth to hospital. Wider social influences such as global capitalism and modernity, which are debated by social theorists such as Beck, Giddens and Lash (1994) or Bauman (2004) will also have to be considered in the positioning of the everyday experience of midwives within society.

To focus on the midwife's experience however one must first consider the major defining context of that work which is pregnancy and labour. We must consider not only its social positioning, but also its embodied, biological and essentially unpredictable nature. It is perhaps too soon to say that an understanding or acceptance of a socially embedded and

uncertain process underpins the philosophy of every home birth midwife, but it helps to provide structure to this evocation of the midwife's day-to-day experience.

Birth as a social phenomenon

A woman's pregnancy fits into, and yet affects the rest of her life. Pregnancy, birth and new parenthood cannot but change one's life. But pregnancy takes nine months (or thereabouts) during which, generally, all is physically well and life goes on. Not only are the social meanings of relationships, male-female pairing, expectancy, new life and parenthood, deeply and significantly personal, they are also enculturated. That is, they are bound up in society's shared or contended significances. The role of the midwife is at one remove from these meanings and is thus even more complex, because midwifery can, in part promote and prepare for the social expectation of birthing, and, in part, question and prepare to challenge those same expectations

Midwifery and birth as social phenomena have, over the past century in Ireland, become less socially integrated and more usually occur in socially segregated spaces, hospitals. This study does not set out to investigate, describe or critique hospital-based maternity services, since this is very adequately done elsewhere (Wagner 1994, Krogstad et al. 2002, Begley and Devane 2003, Baker 2005, Davies 2006, Symon 2006, Green and Baston 2007). Hospital birth and medical ideology have become so much the norm in our society however, that they cannot but impinge on the practice of independent midwives. Home birth is ostensibly outside the norm but certainly not outside the 'influence' of normative expectations.

It is rare now that a midwife, even a community midwife, is so close physically or socially to the expectant woman that she sees her every day. It has become custom and practice that as far as the professional relationship between the woman and her midwife goes, a schedule of visits, premised on the medical ideology of 'monitoring', defines or delimits the 'necessary' interaction between mother and midwife. The mother-midwife interaction is thus 'bitty' or periodic in nature.

Birth as unpredictable

An essential element for understanding the context of home birth midwifery practice is the unpredictable nature of pregnancy and labour. Human gestation (pregnancy lasts approximately nine months (40 weeks) A pregnancy is said to be ‘at term’ from 37 to 42 weeks gestation.²⁹ In this timeframe, a baby born would be expected to be fully mature and birth in these circumstances is associated with a low perinatal mortality. Onset of labour is unpredictable. You cannot know when it will start. By agreeing to be a woman’s midwife for her home birth the midwife is effectively and usually quite explicitly agreeing to be available or ‘on call’ for the labour in the weeks around the expected date of delivery (EDD).³⁰ Labour duration too is highly variable and can be almost imperceptible to some women making it seem very short. The onset of labour may be indistinguishable to the mother from the preparatory contractions of the uterus in late pregnancy (Braxton Hicks contractions) and long latent phases with apparently little discernable progress are well described. These can make labour a very long process with some women describing themselves as being in labour for two, three or even more days. Again this variability and unpredictability is a contextual reality that impinges upon the experience of both the mother and the midwife.

Midwives as social actors in context

It is tricky to describe an independent midwife’s ‘typical’ day and indeed to attempt to do so might, in itself, be a denial of a midwife’s individuality and their personal circumstances. Such denial is a weakness, indeed an injustice in unconscious or even

²⁹ Gestation is measured from the first day of the last menstrual period (LMP), a practice that can be confusing for many women and lay persons who may be very aware that conception cannot have occurred at that time but likely two weeks later. The practice of backdating pregnancies by this two week period facilitated estimation from a stable marker recognisable by the mother (menstruation) rather than any one of a number of possible opportunities for conception. This can ‘throw off’ estimations where babies have been conceived when the woman is on the oral contraceptive pill for example, and can lead to premature babies gestational age having to be ‘recalculated’ from actual likely conception rather than from LMP. I doubt that this detail has to be included for midwife readers, but for non midwife / obstetric readers this is a significant unspoken knowledge that has meaning for the actors being described.

³⁰ Expected date of confinement (EDC) is an older but not entirely redundant terminology that harks back to a time when the woman was ‘confined’, that is expected to be limited or confined if not to bed at least to a smaller social circle and or secluded from broader ‘freer’ social circles. The abbreviation EDC is sometimes still used, even by midwives who would ordinarily express a distaste for the restrictive thinking / ideology inherent in the word confinement.

deliberately patriarchal rationalist research and discourse. I will endeavour to maintain an awareness of this possibility and will be vigilant in my efforts to value and respect the stories of these women in the telling of 'my version'.

Independent midwives practice, perform their midwifery activities and form their relationships with women, in the women's own homes. While there has been a certain loss of sense of community in modern Ireland, certainly in urban settings, in rural Ireland the midwife can still be very much recognised as part of the community, a 'known' and familiar person. Even in urban settings, to choose to have a home birth, or to be a midwife who will attend for a home birth, very much aligns those mothers and midwives with a social model of birth and midwifery. A social model challenges the dominant technocratic model (Davis-Floyd and Mather 2002) which segregates birth from the communities in which the women live and in which the child will grow.

In this vein, Bauman (1993, 2004) talks about the isolating and depersonalising influences of modernity, capitalism and globalisation.³¹ Davis-Floyd (2005), using the term 'post-modern midwife', positions the activities of midwives as reflectively counter to those same disenfranchising influences of late modernity. She argues that midwives are working within and towards more cohesive local communities.

Section two Logistics, balancing the personal and professional

The practical arrangements and negotiations the midwife must make to provide care to women in their professional role has to be balanced with, or take account of their personal, private family and other commitments. This could be constructed or analysed in any number of ways, two immediately suggest themselves. The first is the feminist idea of the 'second shift' (Hochschild and Machun 1989) where employees have not only occupational commitments but also domestic demands on their time and energies. Independent midwives certainly have to balance these two commitments. The second analytical theory that might apply is Goffman's (1973) metaphor of workers being like

³¹ See Edwards and Glover (2001), Bauman (2004, 2005) and Beck (1992, 1999) and Beck, Giddens and Lash (1994) for a fuller critique of globalization, capitalism and neoliberal politics and their effects on social solidarity.

actors on a stage. This leads to the idea of a 'frontstage' and a 'backstage' in social settings. Frontstage are the behaviours the midwife 'performs' as part of their working or professional persona. The backstage describes the essential but 'unofficial' activities the frontstage 'audience' do not see. One of the midwives themselves uses a different metaphor but which captures the same idea. She describes midwives as 'having to be something of a chameleon, presenting different faces to people. 'To be able to adjust and go with the women, their needs, and deal with their issues' (p2L25 FN 21Feb08).

Balancing of the professional and domestic roles is very significant in the day to day lives of midwives, and their context of domiciliary practice is unique in Ireland.

I have used the term logistics to describe the more prosaic and practical aspects of midwifery work in the domiciliary (home) setting. This consideration of the private sphere (Pateman 1988), the backstage (Goffman 1973), the second shift (Hochschild and Machun 1989), or the day to day (Smith 1987) is important. It is important because as these writers demonstrate, it is so often disregarded and it denies the reality of the effort, emotional, physical and social, that goes into maintaining the private and the personal. Every public, frontstage occupation is sustained by the 'work' of the personal, domestic or backstage. This aspect of daily life has classically been ignored as commonplace, but as will be demonstrated in this section, it is particularly relevant in the home birth midwifery setting. The domestic reality of the midwife's context becomes evident in the open social arrangement between the mother and the midwife. The peculiarly 'out of hours' demands of inconveniently unpredictable birth can be particularly demanding upon the midwife and her family.

The major aspects of the logistics of home birth midwifery practice, all of which impact on the personal / domestic context of the midwife, are flexibility, on call, time, workload and place of antenatal care.

Flexibility

Midwives have lives to live into which they must fit, or around which they must arrange, their practice of midwifery and their interactions with the women.

As was outlined above, there are two aspects of pregnancy and birth which make this integration relatively and respectively easy and difficult. Pregnancy takes nine months and the mother and baby are generally well; furthermore, mothers too have their own lives to live. For the duration of the pregnancy therefore, and after the baby is born, the midwife and the mother can negotiate to meet whenever it suits them both. This allows a freedom and flexibility around which other social family and personal demands can be facilitated. Independent midwifery practice can be fitted in before or after other work for example, when the shops are open (or closed), when the midwife's children are in school, or when her husband or partner is available to mind the children, or to make the dinner. This is a flexibility unheard of in hospital practice in Ireland where shift work is the only option. Furthermore, for the independent midwife, renegotiation of appointments is always possible. Again this is an unlikely or difficult scenario for those employed within the rigid constraints of institutional work. Flexibility is time and again cited by the midwives as one of the great benefits of independent practice. It allows the midwife to plan her day, her life, and even to an extent for some, to meet the less flexible demands of a salaried part or full-time job.

On Call

The nature of pregnancy as a protracted but physiologically normal process can facilitate logistical working and accommodate domestic arrangements of both mother and midwife. The nature of labour, its unpredictable onset and duration however, are more problematic in this regard. In order to be available for a mother when she goes into labour the midwife must be in a state of readiness over quite a protracted period of time. In health service parlance this is referred to as being 'on call'.

As has been outlined, the normal (usual) duration of pregnancy (gestation) extends from 37 to 42 completed weeks. For home birth midwives, this five-week period (potentially) of being 'on call' is a considerable burden to independent midwives with knock-on effects on their social, family and personal lives outside their role as midwife. Planning of any activities in this period is therefore contingent upon the woman (or any of several women) not going into labour and requiring the midwife's attention. Several midwives have talked about this demand as being very disruptive, causing them to miss family

weddings, graduations or other social occasions. Some who have stopped midwifery practice spoke of this on-call demand as being a significant factor in their giving up. Having to go 'at a moment's notice' has knock-on effects of the midwife's ability to travel away from home, limits the access of others to the car, limits how much alcohol the midwife may drink. Drink driving limits have been reduced, as has social acceptance of drink driving. Some midwives have identified that drinking and being 'unfit' to drive would, by the same token, make them, or be considered to make them, unfit to practice professionally. I have seen and heard of many examples of how being on call at short notice affects the personal lives of midwives. I have seen where a midwife has laid out her clothes on a chair in the kitchen so as not to disturb her husband should she have to get up in the middle of the night, get dressed and go to a woman in labour. Several midwives have described the difficulty of arranging childcare at short notice. Others identify it as less of a problem overnight when their partner or husband is at home – they can leave the child or children in bed, but when a partner is either not at home or not in flexible work, child care can be a major problem.

'I've been through more au pairs and child minders, They say they can be available any time but when it comes down to it they don't understand that it can be at the drop of a hat' (p27L16 Int 21Apr08). One midwife who practiced into her late seventies used, in those latter years, to have her husband drive her to deliveries. Sometimes he would sit outside in the car until she was ready to come home. Being on call potentially disrupts sleep patterns and while some midwives are very open to being called at any time, some protect their sleep by encouraging the woman who suspects she is in very early labour with no complications (in terms spelt out clearly to the woman) that waiting until morning to call might be appreciated. This kind of practicality, frankness about their own lives and openness about their own needs, seems to be very well understood and accepted by women seeking home birth. At times however some midwives have expressed frustration that women 'just don't appreciate the time you put in... or that you've got a life' (p15L8 FN 21Oct07).

Being disturbed at night is one feature of being on call, another is that the midwife often self-limits aspects of her social life by declining invitations, or having to give only tentative acceptance, explaining that she may be called away. Inviting friends to her own

home can be even more problematic since playing host and being called away are incompatible. Again, in this instance, having a partner or husband to share the burden or carry it in her absence makes it somewhat easier. More usually however, planning of events around expected dates of delivery or, more efficiently, declining to take on women who are due within a particular time period can ‘release’ the midwife for special occasions or for holidays. In order to take say a two-week holiday the midwife needs to create a period on either side where women might ‘go late’ or ‘go early’, For those midwives whose sole income is from independent midwifery, being on-call significantly limits their social relaxations and holiday time or such breaks impact on their potential for earning an income. For women with a family, or those expected to be responsible for domestic chores and care giving, the demands of work elsewhere can be considerable and may go unappreciated at home. The unpredictability of disruption to family routines and expectations can be another layer of stress or source of conflict for the midwife and her dependents.

Workload

Most independent midwives offer an antenatal schedule very like that offered by hospitals (NICE 2008), and are often the sole carer in labour. Most also offer a wider postnatal service than currently on offer in hospital maternity services, which is commonly as little as 24 to 48 hours post delivery. Postnatal care in the community rarely extends beyond a single visit by the Public Health Nurse in the first few days at home. To give a sense of the workload commitment of an independent midwife I have broken down and totalled the care for one woman.

Table 1.

Schedule of Antenatal visits	Gestation
First contact with midwife (usually by telephone)	6 to 12 weeks
First booking visit	12 to 20 weeks usually less than 16 weeks
subsequent visits - (9) primigravidae	20, 24, 28, 32, 36, 38, 39, 40, 41, 42 weeks.
multigravidae – fewer (6) AN visits possible	NICE Guidelines Antenatal Care (2008)
	more frequently after 42 weeks bi-weekly or alternate days

Each of these contacts can be from 40 minutes to 1 ½ hours long but in my experience and observation usually last one hour. That makes a total of eight to eleven hours direct antenatal contact. Some mothers may give birth early but similarly some will go later than term plus fourteen days and may then be seen by their midwife as often as every second day. Some mothers choose to continue to have shared care with their GP and occasionally to continue antenatal visits to hospital. Some midwives may choose therefore to reduce the number of visits they have once the initial booking has been made.

Duration of care in labour

Birth is unpredictable and can be as short as a couple or as long as 24 hours or more in the case of long latent phases in primigravidae. It is rare for a midwife, even where a baby is born before her arrival³² to be in the home less than 2-4 hours. Usually it is considerably longer, perhaps with one overnight monitoring labour progress. The midwife may well not attend in early latent phase of labour, or may visit, assess and return rather than stay continuously. An average of 8 – 12 hours labour care is an estimate based on midwives' and mothers' own stories, not an empirical measurement.

Postnatal care needs vary

Most midwives continue to provide postnatal care for up to 10 to 14 days postnatally and some include a six week postnatal check visit. The midwife almost invariably visits on each of the three postnatal days and then a further 2 to 5 days. The midwife is still available on the phone and may be required more often or for longer periods if there is need for extra breast feeding support.

³² I did not specifically ask about how often babies might be born before the arrival (BBA) of the midwife. Enumeration of this might provide fodder for those adverse to home birth in the first instance, but would in any case, have been anecdotal and incomplete. In my own experience BBAs are usually frightening for the parents and a source of significant disappointment for the midwife. It is interesting that although BBAs may be recorded on birth notification, neither the Neonatal Perinatal Reporting System (NPRS) nor the maternity hospitals give a breakdown of this occurrence. Nor, significantly, do they describe whether they record BBAs when the baby is delivered before arrival to hospital, or only when the third stage (delivery of the placenta) is also complete. This data set (and distinction) might be a significant measure of the appropriateness, or otherwise, of centralization of maternity services and the distance mothers have to travel to maternity services.

It is thus very difficult to quantify the time a midwife spends with each woman. It is difficult also therefore to get a picture of a typical midwifery workload. The following is a very rough estimate and lacks any statistical support. Many sets of circumstances might increase or reduce this commitment beyond even the ranges suggested.

Midwife workload per woman, a provisional ‘guesstimate’. **Table 2.**

Antenatal care	7 – 11 hours (each visit at 1 hour duration)
Intranatal care	4 – 24 hours
Postnatal care	5 – 10 hours
	17- 45 hours
Travel	13 to 22 visits 1 to 2 hours total travel per visit
	13 to 44 hours
Total	30 to 90 hours per mother,
	which, taken over 20 weeks equates to 1 ½ to 4 ½ hours / week
	PLUS up to five weeks of 24 hour on-call

These are direct contact hours and many initial and ongoing contacts between prospective and existing ‘clients’ have not been calculated above. First or booking visits tend to be longer as the mother and midwife may be getting to know each other. These visits may take perhaps two or more hours as a full medical, obstetric and social history are collated. Administrative, liaison and clerical work or professional updating commitments all add to the workload, but cannot be easily quantified so do not appear above.

Administration

I have not asked the midwives to estimate the time spent on documentation and administration. Administrative demand include: annual letters of intention to practice, An Bord Altranais (ABA) registration, and arrangement of practice updating; letters, emails or phone calls to the GP, HSE, PHN, hospital OPD or consultant about each mother and baby’s care; notification of births and metabolic screening tests; contact with

ambulance control, pharmacist, or medical gas suppliers; liaison with alternative therapists if necessary. Time spent on communication varies with the complexity of each case. The midwife is also always available by telephone for consultation, reassurance or conversation with the mother if needed.

Most midwives report that four babies per month is as many as they can manage full time. In order to have one two week holiday annually, they need not to book women for a period of three weeks on either side of that time which leaves ten working months. That is forty births per year (or ten months) being constantly on call, and 28 to 72 hours per week. (Calculated for a midwife attending 40 women per year at 30 -90 hours each, over 44 (52 less 8) working weeks.) Three births per month (averaged) equates to a 20 to 60 hr week.

In 2002 there were 288 home births in Ireland, while in 2006 there were 170 (ERSI 2008). Allowing for a 25% transfer rate (Domiciliary Births Group 2004)³³ that is 360 and 212 booked/planned home births in each of these years. Shared among fifteen midwives, that is a workload of 15 to 24 planned home births per midwife per year. The reported variance amongst the midwives themselves however is from fewer than six per year to 'approximately forty'.

Travel

Travel has been cited as a significant issue and concern for home birth midwives generally (NMH 2001, DBG 2004) and for the independent midwives in this study (p8L23 FN 11Jul08, p2L17 FN 18Sept08). One independent midwife made transport from rural areas to hospital the focus for a Masters thesis. She pointed up the issues both for regular appointments and for emergency transfer from home birth. (Sheeran 2007a and 2007b). Travel time between mother and midwife can be over an hour each way and, even in urban areas, is rarely less than half an hour. It should be noted also that as part of

³³ The Domiciliary Birth Group Evaluation of the pilot schemes (2004) Footnote 6 in chapter 1 was 24% for planned home birth and 36% for planned Domino birth. This compares to 26% prior to or during labour transfers by the independent midwives in the UK (Milan 2005) and 33.5% transfer from the Edgeware birth centre (UK) but only 12% of those in labour who had planned birth centre care (Saunders 2000).

the MOU with the HSE (HSE 2008), the midwife is given transport expenses for seven out of a minimum contracted number of eleven visits. As intranatal and postnatal visits must be to the woman's home, this funding arrangement discourages antenatal home visiting. A few midwives arrange to have some or most of their antenatal visits in their own home in order to reduce travel time.

Place and ritual of antenatal care

Quite a few, but still less than half of the midwives, strive to minimise the impact of the demands of midwifery work by asking women to make their antenatal check up visits in the midwives' own home or in one case, in an office in a health clinic hired for the purpose. Many who make such an arrangement, have set aside a room in their own home as an office cum-meeting, cum-education, cum-consulting room. These are usually comfortably furnished with armchairs, a long sofa, examination couch or therapy/massage table where the woman can lie down with ease for abdominal examination. A second or separate toilet may be close by, and there is often a kettle or access to the kitchen. These rooms, attics or converted garages are sometimes decorated with positive commercial baby and pregnancy images, but more often with framed pictures of happy mothers and newborn babies that the midwife has attended. Pictures sent of subsequent birthdays may adorn the walls, but also decorative gifts, often hand-made by the women themselves and given to the midwife. These rooms and other parts of the midwife's home may be decorated with such paintings, sculptures, mobiles, candles and light catchers. Each has a memory and significance to the midwife and a memory of a birth or relationship with a family she has attended.

It seemed to me that women were very happy to compromise and come to the midwife for antenatal visits.³⁴ They recognised that the midwife was busy or had other demands on her life and time. This reciprocity or recognition of the midwife's work and domestic life demands is discussed below. The women's main concern seemed to be to secure a relationship with the midwife and the possibility of a home birth. The place of antenatal visits seemed less of an issue, perhaps because attending for antenatal clinics in hospital

³⁴ As I assume that most readers of this text will likely be midwives, I do not intend to spell out either the minute actions of an antenatal examination or the rationale for the antenatal visit. These can be found in any contemporary midwifery textbook.

out patient departments or obstetric consulting rooms is so much the norm within Irish maternity services.

The move from care provided exclusively in the women's home, to some antenatal care being provided in the midwife's home or other venue, is quite strongly opposed by other independent midwives who feel that it is precisely the convenience of home visits that women are looking for and for which they are paying. Home visits by obstetricians are now unheard of; even getting a GP to make a home visit, can be very difficult.

The almost ubiquitous ritual of offering tea or coffee to guests in one's home is an aspect that has been striking in the day to day work and life of the independent midwife. Whether in the woman's home or the midwife's the offer of tea is given. Usually it is accepted. The offering may be a courtesy, but the acceptance does signal a leisurely approach with time available for talking rather than focus only on the taking of clinical notes, or taking and recording of measurements. The talk can be of the woman's or midwife's self and family, other mothers on the midwife's case list that the woman may know and ask about. Most commonly, talk is about progress in the pregnancy, physical and emotional wellbeing, or question and answer sessions about aspects of care or household arrangements in and around the time of birth. Sometimes, coffee or herbal tea, juice or water, or biscuits, scones or food were offered and occasionally it was evident that these were a familiar favourite of the mother or midwife. In every case however I felt it was not the taking of the tea or not that was important, but the social signalling of welcome and time to be spent in relationship, familiarity and growing friendship.

Time as quality

Most antenatal visits in the woman's home lasted up to and sometimes, though rarely, over an hour. Visits in other venues such as offices or midwife's home, tended to be shorter (30- 45 minutes). This may have been coincidental. An hour certainly seemed to be the length of time the midwives said they would typically spend at each visit. I find in my own practice that I tend to say to mothers that visits will last 30 to 40 minutes 'but sometimes longer'. On reflection I think this is so that a curtailed visit, for whatever reason, does not leave them feeling short changed and that a longer visit, the more usual

hour, feels like a value added extra. Both a midwife and a student midwife who have come with me on antenatal visits have commented favourably on the length of time spent at each visit and contrasted it with ‘the typical five or ten minute in and out’ experience in hospital after a lengthy wait in an out patients department.

The value of time spent forming the relationship between mother and midwife is possibly best summed up by one of the independent midwives:

‘So that’s, the kind of things that makes it a little bit different, in the system they wouldn’t be given that hour first off. Time is hugely important to women and, you know, no matter how small the complaint is the very fact that they’ve voiced it to you and you’ve said its normal, or it’s not normal and we’ll try and fix it, it means a huge amount to them. So time is, a lot of the women say to me, you know with hindsight, they paid for my time. And that’s an awful thing for a woman to have to say – that they had to pay for time, but that’s what they say they paid for – they paid for me to listen and they paid for me to explain. I feel that I respect women an awful lot more for that, I put in the time. I give them the information for them to make their own informed decisions. And I respect them for that because they know an awful lot by the time, you know, labour comes and if they do have to transfer in labour. I can see it myself, they know exactly what they’re not having, and what they are having and it’s because I’ve genned them up on different aspects of labour really, and you know, the pros and cons of rupture of membranes and of syntocinon acceleration. And they know all of that, I gen them up on that and I do a birth plan with them in case they do have to transfer into hospital. They’re very confident going into labour, be that at home and it end up in hospital, or be that at home and they stay at home. And they know that because I’ve taught them as much as I can. They know that I know that they can make their decisions freely when labour comes.’ (p18L44 Int 17Aug06)

I have demonstrated then, that the practice of midwifery is interwoven into the daily life of the midwife. Temporally, and for each woman, there is a ‘bitty-ness’, a periodicity, to the formal interaction and timing of visits. Even without the many unplanned, but not unexpected, leakages or intrusions, of the mother-midwife relationship into other times and contexts, it is impossible to pinpoint when a midwife is not ‘being’ a midwife. The socially engaged nature of independent practice means that midwifery relationships are in some way always ‘present’ in the broader life and social context of the midwife. Domiciliary midwifery practice, I would argue, is unlike hospital midwifery practice in the degree to which it pervades the entirety of the rest of the midwife’s life. It is this all-

pervasiveness that allows me to describe the life of independent midwifery, as a 'culture'. I have seen and the midwives have described a similarity in their circumstances, contexts, experiences, philosophies and ascription of meanings that allows me to describe these as having a distinct culture; a distinct culture shared by so many (or so few!) seemingly isolated and diverse individuals.

Section three A typical working week

Working as an independent midwife involves a considerable juggling of family and work life. The demands of being on call for labour are somewhat balanced by the freedom to organise the rest of the work. Most of the midwives have partners who share some of the responsibilities of children or dependent relatives. In trying to paint the picture of a typical week however I have not tried to create a composite domestic overlay, not because the personal, familial and domestic is unimportant or insignificant, but because social circumstances are so diverse. I would invite you please, from your own experience, or from your own circumstances, to try to overlay the work demands of independent midwifery with your ongoing family realities. Think of getting school age children out to school in the morning, dropping and collecting them from their sports or social interests. Remember you must still organise whatever shared arrangements you have for cooking and cleaning, shopping and paying the bills. When and how often do you meet any friends? Can you get a baby sitter for an evening out? Your partner's work schedule may need to be considered; how does it overlap, complement or compete with your own? You may have young adult children who have not yet 'flown the nest', you may have older dependent relatives or friends that you care for, or to whom you regularly give some time. You may have a house, and garden and pets to maintain, and holidays you want to take, to organise and to pay for. Your hobbies and social interests, are they ad hoc or time-tabled into your week? Do you meditate, pray or participate in religious worship? Are you politically active? Do you have a second or part time job? Do your days pass with little prospect of ever meeting another human being? Can you drop everything at a moment's notice? I thus invite you to take your own life and try to overlay the work I am about to describe. How would you integrate it? What, if anything, would have to 'give'?

A scenario

You have booked three women for home births who have expected dates for delivery this month. There is every possibility that one, none, or all three will ring you this week saying they are in labour. Two are multiparous and have had fast easy births before. One of them is an hour's drive away. One is primiparous and is now twelve days past her expected date and she is feeling under pressure from the hospital to come in for induction of labour.

One woman had her first baby at home with you just two days ago. Another, who had her baby in hospital as planned and went home within 12 hours, has arranged for you to provide postnatal care. Though an experienced breast feeder, she is having great difficulty latching her baby to the breast and the baby is crying incessantly. She really has not been able to sleep at night and during the day she has been disturbed by her three other children, all under five. These last two postnatal women live close to each other and only half an hour away when there is no rush hour traffic.

You have a dozen women 'on your books' already in the next six months but only have to see four of them this week for planned antenatal appointments. You have two more women whom you said you would attend for home birth later in the year, one you attended before for her first child two years ago and another whom you have never met. You had made preliminary plans to meet them both this week. The first you know well so it should take less time to discuss fully her plans for home birth but you recall she is rhesus negative and declined prophylactic anti-D after the last baby.³⁵

There is a neonatal resuscitation day planned in the local maternity hospital on Thursday, and you have booked a place on it. You missed the last one as you were called to a birth. There is a Home Birth Association meeting next week and you have been asked 'to say a few words' and you still need to prepare something for that. There are three home birth enquiries on your voicemail though one is too far away and one woman has mentioned an obstetric history that makes you wonder if home birth really is a good plan. You need to

³⁵ This part of the scenario is drawn from a field note (p1L11 FN 28Jun06).

ring all three back to arrange to meet or just to discuss things with them. The director of public health nursing has written to you asking you to resubmit the paperwork for a birth you attended last month as the copy you sent seems to be missing a page or contains an illegible photocopy. The Community Midwives Association has sent a huge email attachment asking for comments 'as soon as possible'.

All in all this looks like a normal enough week and you are feeling physically well and optimistic about juggling it all. To top it all, the car is running like a dream and the phone is fully charged. The only thing that cannot be planned for is the onset of labour (or labours!). The antenatal visits and phone calls can be postponed or rescheduled if necessary. The postnatal visits (and metabolic screening for both babies) need to be done this week but again the timing is flexible except that the breast feeding support looks urgent.

This is not an atypical week for an independent midwife. How does it feel ?

A commentary

There are several things in this scenario into which a midwife might have insight and which complicate the picture a little. These might or might not prove to be problematic, and may become the source of extra dilemmas to the independent midwife beyond routine logistics. I will mention them only briefly to illustrate my dilemma in this thesis of trying to integrate not only the logistical balance of work and home life, but also the rather more complex clinical and moral dilemmas that arise as part of home birth midwifery practice. There are the routines and complexities of integrating work and non-work life, but perhaps more significant are the dilemmas, the often contradictory or unsatisfactory compromises that must be made during, and as part of, that practice. Take, for example within this short scenario, some of the more complex issues than the merely logistical.

- 1) The woman who is twelve days past her expected date of delivery is already feeling pressure to accept induction of labour. Guidelines that currently restrict

state indemnified and paid midwifery attendance at home birth, suggest obstetric approval is required for home birth after term plus 14 days. This is a stressor for the woman and a professional dilemma for the midwife. Should she agree or decline to attend after 14 days?

- 2) The woman who is rhesus negative and has declined the anti-D may or may not understand the consequences of iso-immunisation, and may or may not agree to monitoring of this possibility. The midwife may believe that that is the woman's choice, and whatever the woman's choice, decide to attend her. The midwife will be aware however, that should the outcome of pregnancy and birth be anything other than perfect, then meticulous investigation of her (the midwife's) information giving, advice and actions (in this and in the first pregnancy) may follow, with adversarial legal interpretations put on every word and deed. The midwife's prior knowledge of, and relationship with, the woman might make application of standard advice seem like heavy handed professional coercion. The mother and the midwife may feel that explicit repetition is insensitive to her already (apparently) clearly expressed wishes.³⁶

The isolation of independent practice makes it difficult to seek support from peers while working for the autonomy of women making 'out-of-the-ordinary' decisions. Seeking such support from those within hospital structures may expose

³⁶ Refusal to consent recurs as an issue for independent midwives at several points in this study. Notably in relation to refusal of vitamin K for the newborn, refusal of Anti-D as in this example and occasionally refusal to have neonatal metabolic screening. The following extracts exemplify the approach taken by the various bodies responsible for administering or advising about these interventions.

The Health Board Executive Programme of Action for Children (2004:23) refers to '*A Practical Guide to Newborn Screening in Ireland (2001)* [which] states that if parents refuse to allow their infant to be screened they should be requested to indicate their refusal in writing and that a copy should be forwarded to the [Neonatal Screening laboratory] NNSL. Community care areas that have refusal forms are in the minority. In the event of a refusal, it is the policy in most community care areas to contact the NNSL. Draft Refusal form (HBE 2004:63 Appendix 3) contains the wording:

We have read the Department of Health and Children's leaflet on Newborn Screening; this has also been explained to us. We fully understand the gravity of the decision that we are taking by not allowing our baby to be tested. We understand that the medical consequences of not detecting or treating one of these disorders, should our baby have one, might result in severe mental or physical handicap necessitating possible institutional care or in premature death.

Copies of the metabolic refusal forms are included in appendix four.

the midwife to opprobrium for ‘allowing’ the situation. Seeking professional support in this dilemma might perhaps demonstrate a concern for one’s professional reputation rather than for the woman’s birthing autonomy.³⁷

- 3) The woman who lives too far away may have no other choice for an attended home birth. The woman with the poor obstetric history may be similarly constrained. These women (and there are many) must comply with hospital birth or choose the alternative, unattended birth. Can the independent midwife wash her hands of any moral responsibility in declining to take them on? This is a very real dilemma for independent home birth midwives. It is a dilemma that seems not to be felt by the state, the HSE or their employees. If the midwife should go beyond her comfort zone to accommodate the desires or needs of these mothers, she must consider the possible consequences for the women and for herself. The consequences of taking on anything but the most convenient or ‘approved as suitably low risk’ cases is that the midwife is open to criticism for ‘allowing’ or ‘encouraging’ unsafe birth practices. Furthermore, should unfortunate outcomes ensue, blame may be apportioned and the midwife in question held to account. Is it not easier and wiser to decline and absolve oneself of responsibility ? But is such a decision more moral ?

These few dilemmas are only a snapshot of those experienced by independent midwives in their practice. They are specific examples of more complex practice issues than the merely logistical. In ethnography, one strives to tell a story, to focus on the aspects of the world that the actors, in this case the midwives themselves identify as important. Certainly the logistics and practicalities of practicing midwifery in people’s homes, and integrating that practice within one’s own personal and social context, is central to independent midwifery discourse. Yet it is less these logistical details than the relationships they build with women and the dilemmas in which they find themselves, that most occupies midwives’ talk. Relationship and dilemmas are discussed in later

³⁷ The role of a midwifery supervisor in supporting and policing midwifery practice is discussed in chapter eleven. No such position currently exists in Ireland.

chapters of this thesis. The last section of this chapter considers a slightly different aspect of the logistics of independent midwifery practice, that is, the logistics of setting up as an independent practitioner. My own journey towards independent practice makes this ethnography even more explicitly an autoethnography. The following section is largely autobiographical and captures elements of independent practice that might not ordinarily be available to observation alone. My experience as a participant in the world of independent midwifery practice confirms for me, what will be expanded upon later, that it is relationships and dilemmas that best capture the experience, culture and context of independent midwifery practice in Ireland in the first decade of the twenty first century.

Section four Starting out

This section is an autobiographical description of, and reflection upon, the process of moving towards independent midwifery practice. I have endeavoured to capture the experience of contemplating and commencing home birth midwifery with which I think independent midwives will be able to identify.

I make no claims as to the commonality or generalisability of my experience but I have shared aspects of this story with other midwives, using my story as a springboard to explorations of their experience of independent practice.

Scope of practice and gaining home birth experience

A teaching colleague of mine practices as a home birth midwife and was my major inspiration, demonstrating that it was possible to practice home birth in Ireland despite a climate that is distinctly anti home birth. I spoke with her about her practice and about home birth and independent midwifery in general. I spoke with many other hospital based midwives and midwifery teachers too, partly to get their opinions but perhaps mostly to open myself up to the idea of such practice, to air and to begin to address my anxieties about setting up on my own.

A midwife, as expert in normal childbirth, is able to assess whether or not a pregnancy and labour is progressing normally, and to advise or act accordingly. In my role as midwife teacher I have seen that students have ever decreasing experience of caring for

women in intervention-free birth. Both students and midwives working in institutional maternity settings can therefore lose confidence in the normality of birth and in their ability to care for (be with) women seeking minimal intervention. The weight of the final decision in midwifery care in the hospital setting is often referred up to someone more senior. This deference to another (be it obstetrician or senior midwife) undermines confidence in one's capability to make decisions and to feel fully accountable for them. The daunting step then for a midwife contemplating independent community practice is accepting sole responsibility for truly autonomous practice.

An Bord Altranais has guidelines for determining one's scope of practice. The guidelines ask the midwife to consider whether she has had adequate preparation for any new aspect of the role (ABA Code 2000a). Normal, intervention free, birth is not a 'new activity' but the domiciliary setting however is 'new' for an Irish trained and hospital experienced midwife. I believe that the activities of the midwife are the same whether performed in the home or in the hospital. It is often said by midwives that babies 'all come out the same way', and it is true that a complication-free pregnancy tends towards a normal intervention free birth. In some cases maternal or fetal indications suggest that home birth is not the optimal choice. Identifying those indications is not beyond the scope of even a newly registered midwife.

There are so few community midwives and home births in Ireland that there is little or no chance of a student midwife attending even a single home birth. There are so few midwives that there is rarely a second midwife available at a home birth. These two factors further accentuate the isolation and vulnerability of a newly qualified midwife proposing to undertake home birth practice. A midwife at the point of registration should be eligible to practice 'normal' midwifery, but the domiciliary setting is likely to be unfamiliar. The person determining the midwife's capabilities or 'scope of practice' is the midwife herself, but both hospital-based and independent midwives clearly feel that some preparatory experience would be strongly advised. There is some difference of opinion on this matter, with some midwives suggesting that prolonged hospital practice diminishes confidence in one's skills and decision-making, others suggest that hospital

practice gives exposure to a variety of experiences including obstetric emergencies and thus should improve confidence.

It seems that unfamiliarity is at least one factor in midwives' reticence about domiciliary midwifery practice.³⁸ When I suggested 'going out on my own' to 'do' home births, I was met with a considerable wariness, a 'yes, but...' response; even to the point of an audible intake of breath through gritted teeth. The reaction seemed to be a concern for my own wellbeing, perhaps due to recent high profile cases where independent midwives have faced fitness to practice hearings before An Bord Altranias (2009).³⁹

Other midwives asked how I could consider it reasonable that I should offer to be the only midwife present at a home birth. This question suggests one of two possible causes for concern. The first is a concern about my abilities as a novice in the domiciliary setting. The second is a concern that any midwife might practice alone. The first possible meaning of the question causes me (and anyone proposing such practice) to defend my estimation of domiciliary practice as being within my scope of practice. The second is a critique of the circumstances of unsupported practice. It invites the midwife to defend her personal decision rather than being a considered critique of the status quo of women's limited choice about place of birth. I believe this (innocent?) querying, acts as a social, but very real barrier to independent midwifery practice. These typical responses to the suggestion that one would practice independent midwifery suggest that the majority of midwives either believe that home birth practice is difficult or foolhardy, or that they lack the confidence to do it. It is indeed then a brave (or foolhardy) midwife who is willing to present themselves confidently as peculiarly fit for that role.

Midwifery socialisation to the norms of Irish maternity service provision has made an outlier of domiciliary practice. Midwives who choose to offer home birth must be willing to accept being different from the common herd. Neither 'common' nor 'herd' are proposed as derogatory terms but rather to accommodate the label sometimes applied to

³⁸ An anti-homebirth discourse, discussed in chapter four section two, and the logistical demands of independent practice discussed in chapter three, section two, may well also be influential.

³⁹ ABA Fitness to practice hearing outcomes can now be accessed through their website. Their hearings are still held in camera. http://www.nursingboard.ie/en/fitness_to_practise_findings_and_decisions.aspx PDF March 2009-09-04 accessed 4th September 2009.

independent midwives as ‘maverick’ (originally unbranded cattle). The independent midwife certainly has to reflect upon midwifery norms and be able to present herself as uncharacteristically willing, if not uncharacteristically able, to practice fully autonomously. There is a critique of hospitalisation of birth but not necessarily a deliberate critique of hospital midwifery. Her choice however may be read as a critique and rejection of both and thus provoke a reactionary response.

Being a man, I do not suggest my circumstances are typical and more than one midwife has suggested my gendered socialisation may have helped me to make the atypical choice to practice independently. I suggest that reflective consideration, of whether any practice is within one’s scope, is personal. Everyone’s circumstances are individual; the choice to practice independently is not taken lightly. Independent midwives daily swim against the current of Irish maternity service norms. They are, because they must be, strong-willed and confident practitioners. Anyone considering independent midwifery has to ask herself or himself whether she or he has those attributes.

Have I? My several years working in the labour ward, at home and in Africa, made me confident about women’s ability to birth without intervention and my own ability to support them in so doing. My experience teaching others about obstetric emergencies helped me feel I could overcome my anxiety about managing these if they arose at home. Perhaps more importantly however, these experiences allowed me to articulate to others, to my midwifery colleagues, my preparedness and my ability to offer home birth support. It was this aspect, the convincing of others, or perhaps the convincing of myself, that was the most difficult hurdle to overcome when I was considering ‘taking the plunge’ to do home birth. Had I not the blessing or at least the qualified nod of colleagues, I think I could not have undertaken independent practice. Had I not heard their thoughts and concerns, and articulated my arguments in response to them, I would have felt convicted by a jury of my peers.

I have been blessed by the support of my midwifery and teaching colleagues. They are a particularly proactive, reflective, assertive group, who share an ideology that midwifery is an autonomous profession. They have a breadth of international midwifery experience

and one of them has been a home birth midwife for many years. It was this colleague, that most inspired me to follow my dream, to be consistent with my rhetoric, about home birth being appropriate for many if not most women. It was she who inspired me to 'walk the talk'.

Independent midwives demonstrate an eagerness to support other midwives investigating the possibility of home birth practice. They give advice and encouragement and bring them with them to visit mothers and to home births; but it is not an easy decision and many cannot take the final step. I have found and I believe it is true that the hardest part is convincing yourself that you can, when so many around you are convinced that they cannot.

I decided that I should take the opportunity of going with my work colleague who does home births to visit with women and ask if they would be willing to have me attend with her, during their labour and giving birth. Many warmly welcomed me to be there, to participate in their birth experience. They felt strongly that by doing so they are making it more likely, more possible, for other women to also have their babies at home. This is no small thing, but a real generosity on their part and a privilege on mine.

I went with her to several ante and postnatal visits as well as a couple of births which were lovely to be a part of and reminded me how calm and lovely uninterrupted labour and birth could be. The greatest revelation to me was that the central difference between hospital and home birth was in my head. The difference was not in the birth, I knew that I trusted women and their bodies to birth. My anxiety was at being the sole carer, the person at whom the buck stops. The central issue for me then, was the responsibility. I had the skills to monitor and to support, I had the communication skills to encourage and respect the woman's birth choices.

At birth I am patient and optimistic, and for years these qualities had served to open opportunities in the face of the routines and rigidity of the institution. At home however those same tendencies to push the limits could so easily allow me to overstep some indefinite mark, go too far, allow too much leeway, and could serve as my (and the woman's) downfall. I have had to nail my colours to the mast, defend my limits as something potentially other than what the woman might want or have hoped for. It is not that my opinion would overrule, but I must at least know what my limits are. I must

decide when home birth is no longer MY preferred choice. It is easy to be more generous and optimistic than a rigidly pessimistic institution, but home birth has required me to know my own limits. Until that point, and I had never had to ponder, even less to act upon, those limits. Truly I believe the mother is always right, has autonomy over her birthing, but where do I decide that all was not well; and when and how do I make that clear to the woman who has employed me for my knowledge and experience of normal birth?

Gathering the accoutrements

Lesley Hobbs' book 'The Independent Midwife' (1997) and the Royal College of Midwives two-volume 'Home Birth Handbook' (2002, 2003) have comprehensive lists of what a midwife should carry.

The first piece of equipment I sourced was a waterproof fetal heart monitor. This admission is a little embarrassing to me because it is a rather complex piece of technology, a boy toy if you like. Midwifery and normal birth rhetoric questions the use of inappropriate technologies. The use of ultrasonic 'doppler' devices in medicine especially in obstetrics is commonplace, It is assumed to be safe but as many commentators note (Wagner 1994, 2007, Savage 2007), its possible effects are unknown. They suggest that, as in the historical development of the X-ray, unintended and unpleasant side effects might yet come to light.

Whatever about midwives' defence of the 'pinard', which is a simple fetal stethoscope or ear trumpet (Blake 2008), to depend on it solely, would, to me, feel too much like the intransigence of a Luddite. I am led then to ask, is this discourse about 'appropriate' technology about 'credibility'? Midwifery rhetoric implies that 'normal' and 'natural' are generally good, and that technology, while not 'bad', has to have its 'appropriateness' questioned, and its potential impact on the birthing experience closely examined. This would seem to suggest that the pinard is therefore 'good', not despite, but rather because of its somewhat archaic simplicity. To be credible to a midwife, it seems one has to profess a love for the pinard and a wariness of the doppler, or at least be able to articulate its 'appropriateness'. Many writers have considered how technology is the signifier of medical professional status (Jordan 1987, 1992, 1998). The access to and control of

technological equipment is a strong signal of the dominant profession's power (again credibility) in the field (Rothman 1991, Sherwin 1992). (See chapter five on conflicting discourses in contemporary maternity services).

So what is my justification, my rationale, my defence ? How do I balance the competing discourses ? I am on my own (that is I am the sole childbirth professional) and by using the doppler's electronic amplification, all concerned can hear the heart for herself. Indeed it becomes an opportunity to explain my judgements that things are well (or not), the beat (if not the actual rate or its significance) is individually and personally verifiable.

I did also ask my mother (a wood turner) to make a pinard stethoscope for me. Why ? To verify my midwifery credibility to other midwives ? To compensate for the boy toy ? Yes and yes. However this was at least as much because I have internalised these judgements about appropriate technology myself. I have been socialised into the norms of the midwifery discourse. This internalised self regulation is perhaps the ultimate in Foucauldian (1978) disciplinary techniques. I have hardly ever used the pinard, and only in the context of showing another, usually the father, that the heart can be heard with such simple technology. In truth the application of ear to abdomen will do just as well but this would perhaps be a little too intimate, or invasive of the social space, for constant monitoring in labour. Context matters, and while we construct the social, the social also constructs us. It can be seen already that relations of power present themselves as apt for later consideration in what is to be a critical ethnography.

I ordered some equipment through internet sites, and went to a supplier to the ambulance service for others. I bought a child ambu-bag (artificial breathing / resuscitator). I balked initially however at buying another one for the mother. Why ? I have needed to resuscitate babies in hospital, so the potential need for this action at home was apparent. The same precaution applies to the mother it is true, but I have never seen maternal respiratory collapse and I can hardly expect it as a likelihood; but as my very wise midwifery colleague said, 'So ? When a woman does collapse, relying on 'a bit of mouth to mouth' will hardly stand up in defence of the well prepared professional' (p9L34 Diary 28Aug06)

Time and again I will come across this tension between trusting or believing in birth's normality, and the demands of professional standards and norms in our anxious (risk-phobic) society.

Oxygen, entonox and prescription drugs

An Bord Altranais some years ago consulted with the chief pharmacist (presumably pointing out the obvious difficulty of practicing midwifery safely without the necessary life saving drug interventions) and were able to state, in their guidelines to midwives (2001), that a midwife practicing home birth could use a limited list of drugs and fluids in their work. There is separate legislation allowing midwives to carry and administer pethidine that has been prescribed for a particular woman for the purposes of childbirth.

So, armed with the conviction that midwives should have access to drugs, and with a copy of the ABA documentation claiming the chief pharmacist's opinion on the matter, and yet without clear legislation to the effect, I went to my pharmacist. I showed him my current ABA registration and asked for the requisite drugs. My pharmacist, an obliging fellow, whose wife had recently had a baby, agreed to supply them on the submission of a copy of said documentation and a written request for the drugs. This, it would seem, is, and yet is not, a prescription. Some midwives have not been so fortunate and others, on hearing my story have similarly approached their pharmacist. In one case, the midwife only got access to the drugs after the pharmacist had been given 'the OK' directly by the chief pharmacist's office.⁴⁰

Thus emboldened I approached the British Oxygen Company (BOC) and, on production of my ABA card and an 'explanation' by myself, was given access to medical oxygen and entonox by the opening of a direct debit account.

As I contemplated independent practice, I was given an entonox regulator by an independent midwife who was leaving the country. This, as I will explain, was a

⁴⁰ My own pharmacist has since stopped supplying obstetric emergency drugs to me, on advice from the same office. The inconsistency of availability of these midwifery requisites is a concern I return to in chapter eleven.

significant gift. Entonox is a mixture of 50% oxygen and 50% nitrous oxide (N₂O) also known as laughing gas and it is sometimes used in dentistry but more often in A&E or ambulance situations where short term urgent analgesia is required for manipulation of dislocation or similar procedures. It is an inhalation anaesthetic not without its critics (Robertson 2006) mostly because of the risks of prolonged exposure to practitioners, but also because of its nature as an artificial chemical intervention the side effects of which have not been closely examined for mother or baby.

It seems that supply to ambulance services had already eased the way for this transaction; though the statutory restriction upon prescription would, one presumes, apply to medical oxygen and entonox as to any other drug.

A regulator is a mechanical device that allows access to the entonox mixture through a suck release valve not unlike a scuba diving air regulator. This device costs from about €400 on line and although is needed to get the gas out of the BOC cylinder, BOC do not supply or maintain these regulators. Similarly the supply of oxygen regulators are beyond the remit of the BOC supply company. Some independent midwives report that they have a relationship with the medical engineers in a nearby hospital who, out of goodwill, check these devices for them. Others have suggested that a simple self-check of the regulators by another independent midwife at peer review (or as part of the old supervisory visit) might be sufficient. My own initial reaction was to approach the hospital personnel I knew to seek permission to use or borrow one that the hospital no longer uses but the offer of a free one by the midwife removed that need or the financial outlay of buying one. The carriage of gases in private vehicles requires the midwives to display a sticker and to have a means for securing the bottles. As a non-car driver I have asked the parents themselves to arrange (through my account with BOC) to have the oxygen cylinder (and entonox if desired) already in their house from 37 weeks gestation.

Documentation

As mentioned in the introduction, ‘situating home birth and midwifery in Ireland’, several aspects of midwifery practice are addressed in Irish statute. Two I mention here are notification of birth and notification of intention to practice midwifery. An Bord

Altranais as statutory regulatory body has some expectations about midwifery documentation as a means of communicating and recording ‘nursing’ interventions. Hospital norms about the requirements of midwifery documentation also filter into domiciliary practice.

Intention to practice

Midwives, from their earliest recognition in Irish (and British) statute, have had to notify their intention to practice midwifery. This was a means of identifying and controlling which of the early apprenticed rather than formally educated midwives could practice. No such requirement was necessary for nurses and in 1985 hospital midwives no longer had to notify their intention to practice, only non-hospital midwives. Again it seems that regulation and control of birth attendants remains a significant function of the state. The general supervision and control of midwives by the (now) HSE as is required by statute has however been neglected. The independent midwives report that supervision by directors of public health nursing (PHNs) ceased somewhere during the early 1990’s. Midwifery supervision will be addressed again in the later chapters of this thesis as it can be a means not only of control but of support for midwifery practice. At present the notification of intention to practice is a requirement placed upon the midwife that seems to have little impact upon the HSE’s subsequent implementation of their corollary supervisory function. Explicit request for confirmation of receipt of my letter of intention to practice has often been ignored. PHNs have expressed their concern at the unsuitability of supervision of community midwives by PHNs who now have no community midwifery experience. (Institute of Community Health Nursing 2007, DoH&C Commission on Nursing 1998).

Birth notification

Birth notification forms (BNF01) are four page colour-coded carbon copy blanks for the notification of the authorities about the birth of a baby. Copies are sent to the registrar of births, the National Perinatal Reporting System (NPRS) at the Economic and Social research institute (ESRI) and the director of public health and medicine. The fourth copy is held by the person attending delivery who is required to inform or notify the former

authorities. Birth notification and the subsequent registration by the parents, are operations of surveillance and control of the population. The purpose of having the child registered is to give it legal status as a citizen identified with a social security number. It seems therefore that the NPRS ESRI who administer these forms are familiar with independent midwifery practice and have no reservations that a midwife should complete this governmental / civil service task. They have always been helpful and supportive if I have brought them a query or if they have needed clarification on some detail or other. The very direct involvement of the individual midwife in this process is in marked contrast to hospital practice where this function is largely delegated to administrative staff from the labour ward records. The statutory recognition of the midwife and her functions demonstrates her quite significant status within the civil structuring, governance, monitoring and regulation of Irish society.

Other Documentation

Hospital medical or midwifery notes vary considerably, making them difficult to navigate when they are unfamiliar. What they record however is generally pretty much the same. They record the medical, surgical and obstetric history of the woman, the antenatal, intranatal and postnatal care given, the opportunities for education or advice taken, and sometimes, a plan of care designed in a degree of partnership with the woman. Hospital documentation focuses primarily on promoting smooth administrative processing of the woman through the system. Documentation is required of many aspects of policy and procedure that may not directly seem of relevance or benefit to the individual woman but which are designed to suit the institution. As has been described by many other authors,⁴¹ documents and procedures are often centred around risk-based thinking and the rhetoric of choice and consent. It seems however that much of the documentation is also designed to serve the purposes of the system and its employees should litigation, for whatever reason, proceed. A partograph is a diagrammatic representation of the progress of labour. It documents the descent of the baby's head through the pelvis and particularly the dilatation of the cervix along a time axis. The influence of a time limited expectation

⁴¹ Symon (2006), Anderson (2004), Kirkham (2004), O'Boyle (2006), Edwards and Murphy-Lawless (2006) Walsh (2006), Tracy (2006), Perkins (2004)

about the progress of labour is thus made concrete in the framework for documentation of labour in hospital. The original design and derivation of the partograph, its 'curve' (in truth a straight line), and its effect on the management of labour and the thinking of practitioners (midwives and obstetricians) has been articulated at length by other authors (Oakley 1986, Murphy-Lawless 1998, Perkins 2004).⁴² Amongst independent midwives it is contested as counterproductive and unnecessary. Midwives articulate the negative effects of a timed approach to labour, even in institutional maternity care settings. Independent midwives omit this device (this hospital artefact?) from their documentation and, at least rhetorically, from their practice. As will be discussed later however the influence of medicalised thinking and the ingrained practices of active management of birth do impinge on midwifery practice even in the home where these independent midwives deny its sovereignty. They cannot entirely deny its shadow, its influence, its power, particularly in relation to decisions and reactions to transfer from home to hospital. (See transfer as a midwifery dilemma, in chapter eight, page 249).

Taking the final step

So I had now determined that I could and would support women to have a home birth. My self esteem and sense of integrity required that I did, despite the multiple anxieties I had about my abilities or competencies (can I really have doubted them and undertaken to go ahead?). I wrote to the Home Birth Association (of Ireland) and asked them to put my name on their website list as a midwife available in the Dublin area. I also wrote a short introductory biography of myself for the HBA magazine. This was for me the final committing step; I really was going to do it.

⁴² I was torn between delight and horror to read in Perkins' 'Medical Delivery Business' (2004) that Friedman's curve, the 1cm per hour progress curve (line) in the partograph, was derived from a sample of women of which 15% had had their labour augmented by artificial oxytocics. Furthermore he took the best 40% of cases to derive his curve (arguing the rest could be augmented to reach this rate of cervical dilatation) (Perkins 2004:145). Thus the line in the partograph, which so dominates the actions taken upon women in labour in hospital, is not what it is suggested to be, that is normal progress; rather it is particularly abnormal or unusual progress. It is no wonder independent midwives resist using the partograph as a time limited indicator for intervention in labour ('it looks like, but isn't, a partograph' p4L32 FN 29Sept08).

My own feeling is that home birth should be a free at point of delivery service. At that time however (Autumn 2006) there was no state support (grant) for home birth in much of the Dublin area. Deciding how much to charge for my services was a delicate balance between the amount paid for those who could avail of the (inequitable) grant (1250 euro) and what was available through private health insurance (up to 3000 euro). It was also rumoured that obstetricians charged up to 7000 euro for private antenatal care only. What is a midwife worth? I decided 2000 euro was fair with the proviso (in my own head) that if a woman was unable to afford that amount, I would not decline on that basis. The 2000 consisted of 500 euro each for antenatal care, being on call, intranatal and postnatal care.

Within a month of the HBA putting in the contact details on their website, I was getting calls from women looking for a home birth. Word seemed to have spread among the home birth community that there was another midwife 'on the scene'. At that stage I had only the vaguest notion of what geographical spread I might be able to manage. I had in my head quite a circumscribed area. It included my own postal district and the two or three adjoining; it was very much a south inner city Dublin area within a 20 minute cycling distance. I got calls however from women in adjoining counties, Meath, Louth, Wicklow and Kildare which I had to decline. I got none immediately from the vicinity I had envisaged, so I decided to cast my net a little wider, to commutable Dublin city.

Unlike some midwives who took on only multiparous women, or who recommended that I start with multiparous women, I decided to make myself available for first time mothers as well.

From speaking with other independent midwives I had put together a 'terms of service' information sheet to give to women explaining the frequency of antenatal and other visits, mostly I think to clarify for them that the schedule is not so very different from that they would expect in hospital. It also proposed a schedule of divided payments so that most or all would be paid before the birth.

The first women I agreed to take on were both past 20 weeks pregnant when they contacted me. They had booked with their nearest maternity hospital as they had not been able to secure a midwife for home birth. When they heard there was a new midwife on the list and they tried me. I arranged to meet them.

The initial contact

This initial contact is almost invariably over the phone. It is, I find, quite a delicate time in the negotiation and formation of the relationship between midwife and mother. I cannot speak for the women, so I will speak only for myself. I am trying to work out what they are like; what it might be like to be in a close working relationship with them. I feel I have a need to balance presenting myself as a capable professional and as a warm friendly and likeable person. I have inherited from my professionalized and institutionalised practice, a value system that privileges the competent professional somewhat above the personal. There is more to caring than instrumentality; caring is, to a significant degree a loving act (Graham 1983, Campbell 1984, Smith 1992, Oakley 1993). There is a degree of reciprocation too; for me the rewards of my occupation include the personal. Being 'liked', or feeling valued as a person, as well as for my professional skills and knowledge, is part of the satisfaction of the working relationship (Mc Crea and Crute 1991).

But relationship does go beyond the personal; I feel I have to present the competent professional persona as well. I felt it was important to let these first women know that I had comparatively little, indeed negligible home birth experience. I spelt out that I had had some exposure to home births as a student midwife and in the previous few months with other independent midwives, but that I had not been the person responsible for making the professional decisions at those births. I did balance this with my years of experience in hospital labour wards and that the difference, to my mind, was in the timing of decisions regarding possible need to transfer to hospital. I felt that I might therefore be inclined to transfer sooner rather than later. This seemed to reassure. The important question, and which the first woman asked, was 'Do you feel confident and competent to help me with a home birth?' and the important answer was, 'Yes I do.'

What is revealed here is that it is the emotional and mental preparation for undertaking the role as a fully autonomous, responsible and individually accountable professional, that takes the most significant amount of time and energy. This has been my experience and is hinted at in the preparatory visits that other midwives make with the independent midwives but where they do not move to the last stage of undertaking independent midwifery themselves. It is suggested also in the assertion by hospital midwives that they would love to do home births; that they admire independent midwifery but that those who do must be very brave and that they couldn't do it themselves. It suggests to me that home birth midwifery is somehow iconic; it stands for how midwifery should be. Even this early in the telling of the story of independent midwifery in Ireland, belief in women's ability to birth precedes (and might perhaps be undermined by) professional concerns for how birth should be 'properly' managed.

Summary

This chapter has had, as its major focus, the logistical concerns of independent midwifery practice. The explicit positioning of birth within a social context, the home, the family and the community, makes domiciliary midwifery significantly different from hospital midwifery and institutionalised birth. The midwife as a known person and with relationships to others in the community; relationships will be dealt with in the next chapter. This chapter considered another aspect of pregnancy and birth, namely its unpredictability. This chapter has demonstrated how the midwife must organise her own life and responsibilities in order to accommodate the normal and healthy human variation in the physiology of pregnancy and birth. The demands of being on call for labour can be seen to be ameliorated somewhat by the flexibility of antenatal and postnatal practice. What this chapter has demonstrated is that the logistics of practice, or preparing to practice, are not the most significant aspects of domiciliary midwifery. It is rather the personal, relational and ethical aspects of 'being a midwife' that, even now, are presenting themselves as the key features of their (our) lived experience. The following chapters take up these themes.

Chapter Four Relationships

This chapter deals with the highly relational nature of midwifery practice. It is divided into three distinct sections. The first considers the mother-midwife relationship. This is the most significant relationship and close examination of the nature of the relationship; how relationship appears in midwives discourse or rhetoric is considered, but also how the relationship is expressed in observable practice is described. This detailed recording of the mother-midwife relationship is necessary to inform the discussion in chapter six on autonomy. As will be discussed in that chapter, maternal birthing autonomy is predicated upon the midwifery concept of ‘being with’ and upon the mother-midwife relationship built up during the pregnancy. The second section of this chapter describes midwives’ relationships with other professionals and organisations, and the third with the nature of relationships between independent midwives. As with chapter three, the close description of the day to day ordinariness of relationships allows later critical examination of the power dynamics, both within the mother-midwife relationship (chapters six and seven), but also within the broader maternity and Irish social contexts (chapter ten).

Section one Day to day relationships with women

In chapter three, the day to day-ness of family and social disruption were presented as being balanced by the midwife’s freedom to negotiate scheduled appointments. A degree of overlap between the life of the woman and her midwife was described. Their relationship is not just one between professional and client but also involves a degree of involvement with each other in their ordinary lives. This section will describe the ways that relationship is built with the woman through disclosure, familiarity and reciprocity.

A concept of autonomy as relational is central to autonomy in birth or, as Edwards (2001, 2005) describes it, birthing autonomy. The significance of the mother-midwife relationship will be further explored and, in chapter six, explicitly linked to the concept of autonomy.

Continuity and familiarity

Continuity and familiarity between the midwife and woman are not the exclusive purview of independent community midwifery. Midwifery practice in smaller hospitals or birthing units, or the practice of having midwifery teams and midwifery-led antenatal clinics in larger hospitals, can all promote continuity (Sandall et al. 2001, Hatem et al. 2008). It is in large centralised maternity services, where midwifery care is often fragmented into antenatal, intranatal and postnatal care, that continuity and relationship are least evident (Hunt and Symonds 1995, Kirkham 2000, Hatem et al. 2008). If the only valued outcome of pregnancy and birth is the production of a live baby from a live mother, as might be inferred from that fixation in international epidemiological comparisons of women's health, then the independent midwife and the maternity hospital are ostensibly providing the same service. As one independent midwife put it, however: 'there is more to birth than they are being offered in hospitals' (p6L10 FN 19Feb08). Domiciliary practice facilitates relationship, whereas piecemeal hospital practice does not. Community or domiciliary midwifery obviously presents opportunities for integration and relationship in ways not supported in a routine hospital setting. As has been discussed previously, the investment of time is a significant and distinguishing feature of domiciliary and home birth midwifery. In the pressured context of hospital maternity services, time and resources are in short supply and thus relationships are not facilitated. As will be discussed below there is even a counter-relational attitude abroad in institutional midwifery practice where the concept of being over-involved is understood to be a criticism. Independent midwives recognise there are enormous and long term benefits to facilitating successful birthing and the essential basis for that autonomy is relationship.

Mutuality and Reciprocity

Through the continuity of the relationship in repeated antenatal visits, the midwife's familiarity with the woman and her family and social context builds. This promotes recognition of the woman's individuality and a genuinely individualised response as opposed to a 'one size fits all' generic model of care. The ongoing relationship between the mother and the midwife enables the possibility for mutual knowledge of each other's social circumstances rather than just a one way passage of information. In my observation

of independent midwifery practice, and from my own experience, it has become evident that mutuality is a distinctive theme in domiciliary midwifery. Mutuality in relationship is valued by both the mother and the midwife and is, it seems, essential in creating safety. Both Nadine Edwards (2001, 2005) and Elizabeth Smythe (1998) in their work have described the centrality of the relationship between mother and midwife in creating trust and safety in childbirth.

My interpretation is that openness and reciprocity between the mother and midwife about each other's beliefs and social context is valued by them both. Openness and reciprocity are seen in the invitation to sharing social intimacy, and in accommodation of the social context or realities of both their lives. Wherever possible, the mother and midwife will acknowledge and accommodate the multiple and varied demands of the lives into which the new baby will become integrated. The most basic requirement is to integrate the emotional and physical demands of pregnancy, birth and new parenthood into the woman's life. This integration of the pregnancy and anticipated baby into the woman's life extends also to accommodating the person and particular social context of the midwife. The midwife's own social and family busy-ness is explicitly acknowledged and accommodated in their reciprocal planning of ante and postnatal check ups. The woman and midwife want to 'know' each other, and that extends to knowing about the midwife's circumstances. With that 'knowing' comes 'caring' (as in concern for), and in that caring comes accommodating. As a reciprocal arrangement, we care for and accommodate each other. We dialogue, negotiate and accommodate in a way that is not delimited by professional distance and formality but that acknowledges the other's circumstances.

Disclosure

Many women who telephone me looking for a home birth have contacted other midwives. They often tell me that the midwife has told them they are not available because, for example, they are pregnant themselves or that a member of their family is having a baby. This shows a willingness to share personal details where a simple 'I am not available' might suffice. Thus, even when declining to be available, a midwife will

share aspects of her personal life. One can imagine then how much more sharing and interaction will take place when an ongoing relationship is built.

In psychotherapy and counselling, the concept of self-disclosure as a means for building trust and promoting openness in the therapeutic relationship is well recognised (Rogers 1995). Self-disclosure is however more than just a technique, it is a practice that is identifiable in good relationships. Disclosure or sharing can be seen to be associated with valued outcomes like trust. This does not mean however that disclosure is necessarily affected or a cynical means to an end. Many women ask their midwives whether they have any children themselves (p4L19 FN 14Jun06). This invitation to disclosure allows the woman to build up a picture of the midwife, to get a sense that there can be a relationship of trust between them. The particular answer is probably not so much an issue as demonstrating the willingness to share. The mutuality or reciprocity of sharing demonstrates a willingness to be open and to be available. Availability is a concept within midwifery practice that has been associated with effective and satisfying relationships and 'good' professional practice (McCrea and Crute 1991, Lundgren and Berg 2007, McCourt and Stevens 2008, Pembroke and Pembroke 2008). I am a gay man and comfortably 'out' in virtually all circumstances. The question, 'Have you any children yourself?' coming very early in the new relationship allows me to demonstrate (or not) my own openness to personal disclosure. Disclosure however is not always easy and has consequences. Bewley (2000a, 2000b) for example discusses the difficulty for childless midwives of that self-disclosure. There may be some degree of personal pain about some disclosures, but perhaps more significantly there is an element of risk that the other person may judge you on that basis alone. 'She's childless, he's a man, what would they know about birth?' In my experience, exposure of that personal or social 'vulnerability' in open sharing builds a degree of mutual respect and trust.⁴³

Self-disclosure is only one element of reciprocity or mutuality in the mother-midwife relationship, but it signals the importance of this sharing in the whole relationship.

⁴³ Vulnerability also appears in the writing of feminist researchers Behar (1996) and Stanley and Wise (1990), where the open acknowledgement of one's subjectivity and subjective positioning is what a feminist perspective brings anew to knowledge claims based on a putative objectivity. See methodology chapter two in this thesis and Harding (1987, 1996) on strong objectivity.

The closeness of the relationship becomes evident or is demonstrated to an outside observer in many ways. Examples include knowing each other's children's and partner's names and asking after them, looking after one another's gardens or pets when away, or extending social invitations to the midwife's or mother's husband, partner or family.

These expressions, observed by an 'outsider', can only hint at the deeper significance they hold for the mother or the midwife who are on the 'inside' of the relationship.

Relationship therefore has several elements that derive from more than professional awareness of the mother's clinical picture and social context. Social propinquity and overlap of their mutual personal spheres facilitate, but do not necessitate, a more intimate reciprocity. A degree of active and egalitarian sharing of aspects of the midwife's own personal life with the woman is visible in most of the interactions between them. Here are two examples.

One midwife has a young son of primary school age who is familiar with the women attending for antenatal visits because he has been with his mother when she visits them or when they come for antenatal checks in his mother's home. He may play in the same room and is very familiar with abdominal palpation and listening to the fetal heart. He has even developed his own friendships with the women's other children (p16L2 FN 21Oct07). The mother's other children are always actively involved by the mother and the midwife in the whole process of palpation and listening to the fetal heart. Even the youngest is given jobs such as helping to roll up sleeves or fetching tissue to wipe off ultrasonic gel. The midwife's child, like the unborn baby's siblings are exposed to pregnancy and pregnancy care as normal. Many children also play the role of the midwife during the visit with toy versions of equipment or listening in themselves to the fetal heart.

This is not an isolated story: other midwives have reported bringing their children with them on home visits to women, especially when the children are of preschool age or breastfeeding. Although I have not been present in such instances, several midwives speak of breastfeeding her own child while providing professional services to the mother, even during labour (p3L15 FN 15Sept07). While one midwife tells of a general

practitioner's astonishment at this circumstance, it would not be considered an impropriety by most independent midwives with whom I have spoken. Babies need supervision and to have access to the breast; it really should therefore be unremarkable that babies accompany their mothers wherever they go, even in a work context. The midwifery philosophy of promotion of normality is echoed and given substance in normalising breast feeding. It is consistent with a personal and lived expression of one's political (or philosophical) ideology.

Such intimate overlap of domestic arrangements would not be possible, or acceptable in a hospital setting. In the context of home births and the reciprocal accommodation of the mother's and midwife's daily lives, overlap of their social circles becomes possible. The presence of women's own children in their home at midwife visits and or birth is understood to be perfectly normal and thus unremarkable. These practices signal the key differences between institutional birth and home birth. Reciprocity and mutual accommodation is normalised and the context of birth is socially integrated.

The following are two further examples of the mother-midwife relationship that suggest there is more to the relationship than the merely instrumental.

Repeat birthers

'I never refuse a mother I've had before' (p6L13 Int 13Feb07)

There is an unwritten but often strongly felt commitment amongst independent midwives to attend repeat birthers, that is, to be the midwife again for women they have attended before. There is a very explicit affirmation in being asked to attend a woman for a subsequent birth. 'It's such a stroke, such an affirmation when they come back' (p13L14 Diary 11Oct07), it means, or is taken to mean, that you did a good job last time. There is also a palpable sense of pride from a midwife who is able to indicate a brother or sister and say 'I delivered him', or 'She's one of mine'.⁴⁴ This expectation that a midwife will want to attend for a subsequent birth can however meet with disappointment on both sides should the midwife be unavailable. Several midwives have found themselves

⁴⁴ In other contexts the midwives would be loath to say 'delivered', or to claim ownership of the birth, never mind the baby.

unintentionally agreeing to attend more women than they normally would because repeat birthers have particularly asked them to be their midwife again (p6L45 FN 17Oct06).

Separation anxiety

The independent midwives speak of the difficulty they sometimes feel in trying to disengage from their professional relationship with the women in the weeks after the birth. More than one midwife confessed (and one mother suspected) that their method for diminishing the discomfort of the 'last goodbye', which is difficult for both the mother and the midwife, was to defer the official last visit indefinitely. There is nothing still to be done, only the formal ending of the working relationship. The difficulty of 'ending' the relationship and the fugue into a longer-lasting friendship can both be seen as exemplars of how the relationship, the 'professional friendship', in the home birth setting, is often so much more socially engaged. For some midwives, the relationship so carefully nurtured becomes friendship, for some it is 'akin to' friendship, and for some, once the working relationship is over, there is acquaintance only (p3L8 FN 10May06).

The latter two sections have considered the mother-midwife relationship and its sometimes enduring quality. Each mother-midwife relationship necessarily must start somewhere. The following section will discuss the first contact between mother and midwife. As will be explained, it is largely autobiographical.

Intimacy

It can be seen that there is a very intimate relationship between the mother and the midwife. It is built up during the pregnancy and is expressed most intimately at the birth. Their relationship is socially close and as has been demonstrated builds during the pregnancy. During physical examination and in the prolonged course of labour, the relationship is also physically close. The midwife is present in the home, in the secure birth space. She is fully present, as in available to the woman, but she does not have to be physically there all the time. Several midwives talk about not 'labour watching', (p6L9FN 29Sept08) and they articulate a value in the woman drawing upon her own resources and coping with the labour herself. It is often very evident that the woman

needs her own space and can cope very well (even better) without continuous physical presence. The midwife can encourage and console without touching. She offers food and drink, often physically feeding or putting the cup or straw to the mother's lips. Midwives also touch women, and women touch them. They hold, massage, and physically support; they embrace, walk and dance, rock and sway together. Midwives will touch the woman's abdomen to feel the contractions of the uterus ebb and flow, and to palpate position of the baby in the uterus. They may also place their fingers within the woman's vagina to determine dilatation of the cervix or descent of the head through the birth canal. They will wipe a brow, mop up blood or faeces, hold a receptacle to catch urine, wash, dress and change linen. They will shape a breast for feeding or use their fingers to express milk if necessary. This all is most intimate touching. Social distance and intimacy need to be very carefully judged to feel safe and appropriate. There is need for a great deal of trust between the mother and the midwife; indeed between all present at the birth. Relationship builds trust and safety. Caring is physical, it is psychological and it is emotional and through all this it is relational.

Midwives value relationship

Midwives value the relationships they have with women. The positive aspects of the relationship apply not only to the mother but also to them.

‘The most important thing is the relationship with the other person, whether it's someone this size (holds up thumb and finger about two inches apart) or someone elderly.’ (p4L34 Int 20Jan08)

‘it is the strength of the relationship, the warmth and significance of the friendships, you effectively have a friend for life’ (p15L22 Int 13Feb07)

They report (and I can confirm) the great satisfaction and pleasure they draw from practicing autonomously and from sharing the delight at the emergence of new life. Most importantly there is the pride in oneself, in the family, but particularly in the woman who engages fully in her birth. Using and being assisted to use her birthing autonomy, she is transformed into a stronger more confident and enriched person who feels empowered to journey confidently towards the responsibilities of parenthood (p2L18 FN 27Sept06). This very much echoes the work of Mary Cronk (2000:23) who says:

‘I believe that our assumption of power over the women for whose benefit we practise at the beginning of their parenting can begin their disempowerment as parents and take from the feeling of responsibility for the children on which good parenting depends. Our input in terms of nurturing, enhancing and respecting the development of feelings of parental responsibility will, I believe, benefit society.’

Difficulties

The intimacy and mutuality of the relationship which are valued by the midwives are sometimes not without their difficulties. A more comprehensive set of dilemmas that midwives face in their practice will be discussed later. I separate difficulties arising from the close mother-midwife relationship from the others however and include them here firstly because they fit well within this section. Secondly, I separate them from other midwifery dilemmas because I believe that while the independent midwives can identify the personal and logistical costs of their working closely with women in a social model of birth, they accept those costs. To me, and to other independent midwives, the rewards of relationship far outweigh the few, but very real, costs of relationship.

Ruth Wilkins (1993b, 2000) is explicit in her critique of the paucity of the professional paradigm in midwifery. She articulates that midwifery’s allegiance to professionalism, to scientific enquiry and the methodological rigour of the randomised control trial leaves midwifery without a means of accessing or exploring the personal. She proposes that a personal paradigm in midwifery and midwifery research is more consistent with midwifery’s central tenet of ‘being with women’. A personal paradigm, unlike a professional paradigm, acknowledges the significance of relationship. A personal paradigm values and makes central the subjective experience of the woman. It allows that women describe the relationship they have with their midwife as friendship and can allow the midwife’s commitment to the relationship as friendship also. The professional paradigm by implicitly and explicitly excluding the personal, cannot, or at best strains to accommodate relational and subjective concepts such as friendship or emotionality.

Professional or Friend?

This strain between the personal and the professional can be seen in Sally Pairman's combined concept of the professional friend (Pairman 2000). Mothers are often explicit in describing the relationship between them and their midwife as friendship (O'Connor 1995, Smythe 1998 and Edwards 2005). The same writers however, describing the experience of women seeking and having home births, suggest that midwives may not always seem to appreciate their influence on the experience of women. Women can perceive that the midwife puts the relationship secondary to policy and protocol. Midwives seem more reluctant to describe the relationship as friendship, describing it instead as 'like' friendship but not being 'genuine' friendship. Pairman (2000) contends that it is not 'really' a friendship given its delimited nature as only in the context of the pregnancy and birth. Other constructions of the relationship describe the midwife as an 'anchored companion' (Lundgren and Dahlberg 2002) in their attempt to capture the dual nature of the relationship.

Dichotomous thinking is problematic because it tends to render invisible that which is most interesting namely, the grey area between the extremes (Jordanova 1989, Martin 2001).

As with so much in this ethnography, my observations and conversations with the independent midwives reveal a spectrum of attitudes in relation to this issue.

The independent midwives in this study approached and interpreted their relationships with women in a variety of ways within the spectrum of professional friendship. Their rhetoric is often concerned to display the professional nature of the relationship, while their behaviours are often more intimate than 'coolly' distant (McCrea et al 1998). McCrea and Crute (1991) describe midwives wanting to be needed, and also to be recognised for their knowledge and skills. Independent midwives display skills that are both professional and relational, personal and technical, communicative and instrumental. It is difficult to resist presenting these as dualisms. However, my overall intention for this discussion of the personal and professional is integrative and holistic rather than oppositional.

Professional distance

Some independent midwives do not appear to share as much of their personal lives, in word or in practice, with the women they attend. They choose instead to maintain a slightly more formal distance with regard to their personal lives. A certain professional aloofness pervades. There is a warmth and openness to the woman but a degree of reticence about the midwife's own circumstances. This is very much a model of professional distance encouraged in institutional settings that separate the professional from the private spheres both physically and temporally but also socially (McCrea and Crute 1991). One independent midwife, for example, chooses to wear a simple uniform tunic with the word 'midwife' embroidered on it.

These examples suggest that some of the trappings and social practices deemed 'professional' can persist in domiciliary practice. Why they persist may be due to tensions that I identify later in the thesis, between the demands of relationship and professionalism. The maintenance of a certain 'professional distance' may make it easier for the midwife to signal clearly whenever clinical indications impinge upon expectations.

Particular examples of relationships that are more professionally distant than warmly personal, do not however detract from the whole discussion of mutuality and reciprocity. Overall the independent midwives in this study actively engage, and definitely see value in mutual reciprocal relationship. It is perhaps part of the vulnerability of this mutuality that it can, on occasion, also have negative consequences in the form of emotional costs for the midwife.

Friendship

In independent midwifery practice there are many examples of social intimacy that would not be seen in institutionalised working relationships: staying overnight in the woman's house after birth, sharing meals before or during midwifery visits or in early labour. Midwives have even offered their own home as a place of refuge in times of trouble. Beyond the formal context of the pregnancy and birth, the personal, ongoing or explicitly friendly nature of the relationship between the mother and the midwife can be further revealed. It can be heard in conversations, it can be seen in chance meetings on the street.

It can be seen in receiving christening or first birthday party invitations and deciding whether or not to go. The significance of the relationship between mother and midwife can be seen in the making of little gifts or mementos for the baby or of the birth, and in the sharing of photographs, letters and phone calls often years later. Shared engagement in politics or birth campaigning can also maintain a common bond. Midwives and women tell of recognising each other on TV or radio, and will keep home birth-related newspaper cuttings for each other.

The stories of reciprocity, mutuality, disclosure and persistence of the relationship long after the birth would all seem to be indications of the mother-midwife relationship being close to genuine friendship. It is quite common too for friends of a midwife to ask specifically if the midwife will attend them for a home birth. In these instances of course the friendship precedes and persists beyond the professional relationship. In a personal paradigm that accommodates friendship, these behaviours are understandable. The professional paradigm cannot easily interpret these behaviours and might determine them as inappropriate, over-involved or contestable for other professional concerns such as accountability or indemnification.

Emotion work in relationship

A second lens through which the mother-midwife relationship might be viewed is that of emotion work. Arlie Hochschild (1983) first described the concept of emotion work amongst flight attendants who have to present themselves as upbeat and positive as an essential part of their work in keeping their customers happy. The concept has been expanded into other areas including midwifery, by writers such as Billie Hunter (Hunter 2001 and 2004, Hunter et al 2008, Hunter and Deery 2008, Mc Court and Stevens 2008) which is not inappropriate given the highly emotional nature of birthing and the midwife's role in preparing for and supporting the woman through pregnancy and childbirth.

One midwife speaks of her role in getting women 'into the emotional space to be ready for the home delivery' (p9L40 FN 07Jul06). Another described a woman she was with as

swinging between emotional highs and lows and when the woman was crying said to her that letting go of tears is good (p25L38 FN 20Nov06).

Maternal anxiety or worry is repeatedly cited as a significant emotion for pregnant women (and their partners) and it is described as having a negative effect on labour (p2L31 FN 29Sept08, p2L36 FN 07Jul07, p5L22 FN 17Oct06).

Being in very close relationship with another doing emotional work requires an awareness not only of their emotional state but also of one's own. My own experience and midwives' description of their work constantly demonstrated how emotional self-control is an integral part of midwifery relationship work.

One midwife says: 'you need to mind yourself going into that kind of situation' (one that will take a lot of emotional support) and she particularly recommends having someone like a doula present to support the women in labour. The emotionally draining effect of supporting another is captured by several midwives who make reference to the possibility of someone 'pulling out of you' emotionally (p19L16, p25L24 and p26L11 FN 20Nov06 and p15L8 Int 18Sept08). Another talks about 'you have to be tough, to protect yourself from the energy you're getting from the women' (p9L6 FN 20Nov06).

Having professional insight into clinical situations of which the mother or parents may not (yet or ever) be aware, can require emotional self-control. One midwife captures this saying: 'your blood goes cold' 'you take it on, they don't' (p27L31 FN 20Nov06). This aspect of the midwives' own worries as distinct from the mothers', is a recurrent theme in midwifery emotion work (p34L45 and p20L40 FN 20Nov06) even when those worries turn out to be unfounded and all is well (p2L16 FN 21Feb08).

Emotional engagement in the relationship as part of the work can be demanding. One midwife feels that she needs a bit of space and time before and after each antenatal visit to prepare for or unwind after the session to get 'head space' to be emotionally prepared or (self) debriefed (p9L18 and p15L2 FN 21Oct07).

The same midwife articulates an overlap between the work and life worlds impinging upon each other that is echoed by other independent midwives. 'It affects you if things

are happening in your family and you are on call'(p9L18 FN 21Oct07). Another reports: 'Transfers sometimes have been as much to do with me as it has with them. I have run out of energy' (p8L3 FN 11Jul08).

These quotes begin to indicate how the close relationship and emotional nature of midwifery work can take its toll.

Boundaries ?

Perhaps one of the greatest difficulties in living a moral life is deciding where to draw one's boundaries. What is the boundary between selfishness and selflessness ? There seems to be a moral evaluation of selfishness, that is meanness, self-seeking and self-serving, or as they say in Ireland '*me fein-ism*' (gaelic for myself –ism), as bad. Selflessness, expressed as generosity, forgiveness, openness and doing for others, on the other hand is considered to be morally good. There are however limits and they are suggested by terms like being 'over-involved' which (along with claims to objectivity, discussed briefly in the methodology chapter two section five and later in chapter five) seems to underpin professional distance. There seems to be a wariness not to be taken advantage of, that there is a cut off between social good and personal disadvantage. Independent midwives are neither gullible saps nor selfless martyrs and would certainly not want to be portrayed as either. They do however seem to be willing to tread closer to the boundaries of human generosity than is deemed prudent in contemporary western maternity institutions. The concept of relationship in birth is certainly central in independent midwifery praxis. The more complex construct of relational autonomy is discussed later in the thesis as a means of conceptualising relationship and birthing.

The importance of the mother-midwife relationship is visible in the day to day experience of both mother and midwife. The distinction between a professional and personal construction of the relationship exists not only in midwifery writing but also in the experience and rhetoric of the midwives. There is variation between midwives with some being more personally engaged than others. There is a tension between the rhetoric of 'being with' a woman and the rhetoric of 'being professional'. This is a tension that is a

central finding of the study, and it is explored more fully later in the thesis. Observable behaviours outlined in this section demonstrate an intimacy in the mother-midwife relationship that is clear evidence that they are ‘being with’ the woman personally and socially throughout the pregnancy. Other relationships that midwives are engaged in on a day to day basis will however be outlined in the next section.

Section two Day to day relationships with others

There are many significant actors in the independent midwifery scene and the relationships midwives have with each must be explored. This section examines aspects of midwives’ relationships with obstetricians, hospital midwives, GPs, PHNs, complementary therapists and maternity interest groups.⁴⁵

Obstetricians

Obstetrics is the dominant profession in childbirth. How this dominance plays out in the day to day relationships and considerations of the independent midwife will be expanded upon in this section. Professionalism and professionalization are analysed in chapter seven.

Not doctor bashing

Not all midwives have had a negative experience when dealing with all obstetricians. Many IMWs tell of working relationships with individual obstetricians that have been positive, respectful and very supportive. Most midwives are keen to avoid being seen as ‘doctor-bashing’ in their recounting of tales of hospital interaction. Doctor-bashing is a term that describes a tendency within midwifery writings to present obstetrics as the opposition when exploring the philosophical differences, the occupational competition, rivalry, or boundary disputes between midwifery and obstetrics. Critique of individual poor practice is a different and legitimate issue but not the subject matter of this thesis. Critique of the power dynamics that exist in the maternity services is important, as exploration uncovers the mechanisms of the status quo and invites speculation on how

⁴⁵ Midwives’ relationship with larger entities such as the health service executive (HSE) and An Bord Altranais (ABA) are mentioned in the introductory chapters situating birth and midwifery in Ireland.

those relations might be different. I am tempted to say how they ‘might be better’, but then of course I would have to ask, for whom? Analysis of the operations of power in relationships between obstetricians and midwives, between obstetricians and women, and between midwives and women, is likely more threatening to the more powerful in each pairing if, as is the intent, a more equitable relationship is proposed. Discourses of empowerment of the underdog, that permeate socialist or feminist writing and critique, necessarily challenge those in power. In this light, critique might be construed as doctor bashing, but is not unreflective and it is not an attack.

Singer (1990) castigates medical anthropology for having so long acquiesced to a biomedical perspective when examining health and medical practices.

‘The clinical bias of medical anthropology fosters a studied ignorance of the non medical behaviours of medicine, including its political maneuvering to eliminate competitors and gain social status and power; propaganda activity to stimulate medical needs and implant the clinical view of reality in public consciousness; manipulation of social values such that politics and social patterns beneficial for medicine are presented as beneficial for the patient; and, the promotion of medicine’s ‘scientific’ veneer to legitimize intrusions of mind and body on a mass scale; ‘ (Singer 1990:181)

The overall message in this ethnography is that the working relationship between hospitals, as institutions, and independent midwives can be problematic; problematic for the midwife, for the mother, and for the hospital personnel - the obstetricians and hospital midwives. This consideration of some of the discourses about birth and the structural arrangements of maternity services has been a necessary precursor to understanding the power relationships between the professional actors in the scene. Similar critical examination of the power relations between the midwife and the woman will also be presented.

Several aspects of the obstetrician midwife relationship have either been mentioned or will be explored more fully in later sections. Professionalization is discussed as a separate topic later in the thesis and the concept of occupational closure strategies, where professions seek to delineate their scope and authority will be examined again in relation to midwifery and obstetrics (chapter seven). The transfer of planned home birth to

hospital is identified as a particular stressor for midwives and is discussed in chapter eight (page 249) which examines midwifery dilemmas. The relationship between midwives and hospital staff, particularly at transfer, is discussed there. Here, I will give a brief examination of midwives' perceptions of home birth antagonism and occupational rivalry which does not appear elsewhere. Other, more positive examples of communication and collaboration also exist and are outlined.

Antipathy

An antipathy amongst doctors (GPs and obstetricians) to home birth is evident. It is not universal, with many saying home birth is a reasonable choice for some women in appropriately supported circumstances. That anyone other than the woman might decide her suitability is not identified as problematic; nor is the fact that Irish maternity structures do not support but rather obstruct home birth as a choice and make no provision for facilitating it. These structural hindrances are seen as reasons for not having a home birth rather than identified as features that should be changed to facilitate choice. To be fair these responses are typical of lay people, health service managers and other professionals, not just doctors, but obstetricians as the most influential and authoritative voice in maternity services, in their failure to address the status quo reveal their lack of commitment to real birth choice.

Unconvincing rhetorical support for home birth is one thing, disinclination to provide the service oneself is another which does not of itself obstruct others. There are however several examples of active obstruction of home birth and of obstruction of midwives who would attend at home birth. Marie O'Connor's work (1995) clearly demonstrates that in Ireland (as elsewhere) women come under considerable pressure not to birth at home. Horror stories abound (p36L4 FN 20Nov06), and women are asked 'what if...?' suggesting, rightly, that blame (self blame or by others) associates with choice. The link between rights and responsibilities becomes morphed into choice and blame.

In 2003 the Masters of the Dublin maternity hospitals⁴⁶ decided their hospitals would stop providing antenatal blood tests and ultrasound scanning services to women planning

⁴⁶ There is a fourth much smaller, fully private, maternity hospital in Dublin called Mount Carmel.

home birth with independent midwives. This was without consultation with the independent midwives or the Health Service Executive (HSE) which funds public maternity services. There was no apparent disquiet on the part of the midwifery management in the hospitals at this move. Until this point, the independent midwives in the greater Dublin area had been able, on their own authority, to request these services. The precise mechanism for requesting and getting reports back from such tests varies across the country. Many midwives have, and had, good relationships with the maternity hospitals even some who were then affected by the blanket ban (p2L15 FN 11Mar07). One of the reasons reportedly given to midwives for this move was that it was unclear what the indemnification implications of this practice might be. This hardly seems a valid excuse either for a concerted response from the three Masters simultaneously as no advice from private or HSE insurers expressing such a concern was offered nor was any time scale for the investigation of this putative problem.

A midwifery teacher colleague and I went to speak to the master of the Rotunda to express our concern that this was an unfair withholding of public services from women and a slight to the profession of midwifery. My understanding of the response we received was that there was a collective concern for the practices of individual midwives and that the lack of a mechanism for governance of midwives or review of their practice. The master suggested that they hoped the withdrawal would force the midwives to regulate their practice. There was no indication of what exactly they meant by governance and regulation, no offer of models that they themselves use, or any indication of support for the midwives to devise one. They felt they had the right, indeed obligation, to act as they did and that the ball was now in the midwives' court (p10L3 Diary 09Aug05).

The following excerpts from an interview with one of the midwives outline some of the reaction to this unilateral action.

‘so you know that’s what you are, your constantly on the back foot, you know they’re in a hugely, they’re in the dominant position and they’re also very organised together and you know they’re able to withdraw scans and bloods, across the three hospitals all at once. (p33L14 Int 05Jun07)

If the obstetricians had been hoping for increased transparency, the action was counterproductive.

‘that’s exactly right yeah, they must conceal their plan of having a home birth because otherwise they won’t get their bloods and scans done.’

‘It undermines the safety of the mother and the baby you know in an emergency situation, they have to conceal that they’re planning a home birth. It also means that they are utilising, doubling up on the use of services which doesn’t make a lot of sense at a time when the services are so stretched but you know the hospitals, the masters have made that decision and that’s not again our problem, we just work around it.’ (p41L12 Int 05Jun07)

This midwife very clearly suspects that this action was part of a concerted pattern of interventions, including using midwifery professional governance structures to control or obstruct the activities of independent midwives.

‘Yeah, there was a very clear agenda and has been and always will be no doubt. But the [O’Ceallaigh ABA fitness to practice] case concluded in whatever year, I think it was 2002, so that that strategy didn’t work for obstetrics.

[Yes to try and control it from the outside.]

No to try and have her taken out, and the publicity that they would have got against the self employed midwifery sector, you know they would have been hoping if you pull Ann Kelly you’ll pull them all down. So that strategy was lost, she won her case, that was in 2002. And then in 2003, early 2003 that was their next strategy, was to pull the bloods and scans. So you’d have to understand that it’s very clear the process they have adopted. And then also in 2003 or 2004 whichever year the Supreme Court case was, the Supreme Court case judgement was in November it was no coincidence on the 1st of September they got the headline in the Sunday newspaper that babies born at home were seven to eight times more likely to die.’ (p51 L1 Int 05Jun07)

‘Why would they withdraw bloods and scans then on the grounds they are vicariously liable and when it is confirmed that they’re not vicariously liable, that they don’t reinstate them immediately. Why did they publish scientifically fraudulent papers⁴⁷ two months before the Supreme Court judgement on women’s rights to a home birth. I mean you have to just ask yourself, you know look at the facts in front of you, it’s glaringly obvious I would have thought, it’s about power and control, first and foremost and then money flows from that of course. It’s

⁴⁷ The paper that this midwife characterises as ‘fraudulent’ is the one by McKenna and Matthews (2003) referred to in chapter one p. 19. They are, respectively, an obstetric consultant and ex-master of the Rotunda Maternity Hospital in Dublin, and a paediatric consultant also in the Rotunda. Their assertion that statistics indicated poorer perinatal outcomes for home birth is methodologically flawed in its comparison of very small numbers of home births, lack of control for variables and significant gaps in the data set. The paper also contains statements unsupported by the data presented. It has been critiqued in letters to the same journal by MacFarlane (2004) and Murray (2004).

power and control, end of story, that's what it is and you know they don't want the fact that a midwife might legitimately be recognised.' (p51 L22 Int 05Jun07)

The feeling then, amongst independent midwives, is that there is an antagonism abroad to home birth and to independent midwifery that is revealed concretely in these examples, in their talk with mothers seeking home births, and in their own experience.

Liaison and communication

Liaison and communication between parts of the maternity services is considered a universal good. Good communication requires all parties to engage and sometimes liaison is very effective. It should be noted that hospitals in other areas of Ireland did not withdraw access to diagnostic tests and midwives report good working relationships with some (but by no means all) hospitals and consultant obstetricians. As will be seen in the section on transfers to hospitals (chapter eight p240) it is the obstetric registrars that independent midwives find most likely to respond efficiently and appropriately.

Independent midwives report making efforts to make contact with the hospitals in their area to be known to them and have arrangements in place for liaison, for when transfer is necessary and for the requesting and reposting of diagnostic tests. The Cork home birth scheme has a steering group and a midwifery co-ordinator which facilitate the smooth operation of the scheme and promote good communication between all parties. Many independent midwives speak of obstetric consultants who are respectful, supportive and even encouraging of their efforts to give home birth choice to women.

Hospital midwives

While this ethnography has not sought the opinions of hospital midwives on the topic of home birth, the independent midwives, who are central to the study, have worked in hospital settings (at the very least as part of their training⁴⁸) and have chosen not to continue to work there.⁴⁹

⁴⁸ Even using the word 'training' is contentious with many midwives, especially midwife educators, preferring the word 'education'. 'Education' suggests having a higher intellectual status than 'training' which suggests a more mechanical or technical role, or rote learning. I would suggest that this is in no small part due to an appeal to professionalism and a distinct body of knowledge and academic rigour (all of which are discussed in chapter seven on professionalism). There is much within midwifery practice however, that is very much experiential and practical and cannot become integrated into the practice of

Hospital midwives have told me and other independent midwives that we are ‘very brave’. To me it seems they recognise that there are challenges to practicing independently or in providing home birth. Very often at the same time, they will say ‘I’d love to do that’. This too requires some dissection. There is obviously something about home birth and domiciliary practice that they admire.

I can answer none of these questions for the hospital midwives except by inference from the stories of the independent midwives which form the main body of this ethnography.

It strikes me however that there is something iconic about home birth midwifery that captures much of the rhetoric of a midwifery philosophy predicated on normality of birth, women’s birthing autonomy and their inherent ability to birth.

In general, the independent midwives find some hospital midwives very supportive of independent practice. This can be in kind words and supportive language when bringing women to hospital on transfer, or when requesting bloods, scans and laboratory results. It can be in supportive actions by guiding independent midwives’ clients towards sympathetic registrars or consultants. They may be of practical help by providing equipment or consumables for independent midwifery practice or by facilitating disposal of placentas or contaminated materials. They may offer flexibility rather than strict adherence to guidelines and protocols or, on occasion, they may help collude in providing choices to women that might not ordinarily be available. Somehow, knowing that the woman has chosen a different model for her maternity services encourages ‘out of the box’ thinking when dealing with them, even within the routine maternity services (p4L15 FN 28Jun06). Some independent midwives however describe incidents where the hospital midwife has been less than supportive of a woman’s decision to home birth and of their domiciliary practice (p1L17 FN 24Sept07, p3L2 Diary 13Oct06, p7L16 FN 21Oct07, p45L15 Diary 18Apr06).

midwifery by intellectual effort alone.

⁴⁹ A few do work part time as hospital midwives. Some midwife hospital-employees provide home birth support as part of hospital funded and supported outreach to a circumscribed geographical area of the local community. These latter do not form part of this ethnography, my rationale is that they form a cultural community embedded within hospital structures, rather than facing the demands of independent practice. There is scope for examining the differences and commonalities of this group and the independent midwives in subsequent research.

Hospital-based midwives, like obstetricians demonstrate a variety of responses to home birth. In relation to independent midwifery practitioners there are not the same grounds for occupational rivalry. Hospital-based midwives range from being supportive colleagues who share the same basic ideals, to those who perhaps fear independent practice might bring the broader midwifery profession into disrepute.

These conclusions are quite speculative and certainly would benefit from a focused exploration of the attitudes and experiences of hospital based midwives about home birth. However this is beyond the scope of this study.

General Practitioners

Again as with other professional groups there is a full range of possible reactions to home birth and independent midwifery. Many older GPs would have attended home deliveries themselves and thus are familiar and possibly warm (but possibly not) to the idea, and will support women's decisions and midwife requests to facilitate home birth. Others have little regard for home birth or midwifery and refuse to accommodate their 'patients' making such a decision. They can refuse to carry pro-home birth literature, even at times refusing to accept such women as their patients. This is despite the fact that most GPs are happy to share care with hospital obstetric consultants and accept payment for such care under the Mother and Infant Care scheme (MICS).⁵⁰

The GPs are however in a difficult position on at least two counts. Firstly, as students they get very little opportunity to see / attend normal birth sometimes delivering as few as 6 in their rotation. They also in that same experience see a lot of obstetric interventions, C/S, vacuum, and forceps deliveries that are presented as essential to save the life of mother or baby. Their status as generalist is counter to a pattern of increasing specialisation amongst the medical fraternity; increasing specialism that brings with it increased status and prestige (Foucault 1973, Hearn 1982). GPs therefore no longer may feel they have the skills and experience to attend births themselves. (O'Connell et al. 1998). They seem very reassured to be told by the IMW that they will not be called to delivery and that transfer to hospital is the course of action in cases of variation from the

⁵⁰ See situating home birth which mentions how means tested maternity care was introduced (MICS) in the 1947 Health Act, and how public maternity care is now (since 1990) free through the same scheme.

norm. Secondly, GPs are privately insured for their practice, and several GPs have told me that their insurers explicitly exclude involvement in home birth as a condition of their cover.⁵¹

Midwifery professional relationship strategies

Midwives use different strategies in their relations with other maternity service professionals. All the independent midwives take their autonomous practice seriously which means they accept individual responsibility for all aspects of their practice.

Some make minimal contact with other reproductive, maternity, health and social services and do not cultivate close or any working relationships with them except in the case of transfer for intervention not possible in the home.

It is perhaps these midwives that most unsettle the powers that be. The state sanctioned maternity services only learn that these woman and their midwives exist if they seek hospital or obstetric treatment. As these, indeed most women, do not need obstetric intervention they may never become visible on the obstetric ‘radar’. The possible reasons for such a disconnected mode of practice is not surprising if the mothers and or midwives have experienced some of the prejudices outlined above.

Other independent midwives, especially those setting up new practices, make significant efforts to make themselves known. They make contact with GPs in their area and the maternity hospitals with which they may have dealings. Independent midwives have, in many cases, written to, spoken on telephone with, and visited each facility and made an effort to speak particularly with antenatal and labour wards staff, midwives, managers and obstetric staff. These midwives’ rationale is that by making themselves visible and known to these individuals, and to the ‘system’, they are smoothing the way for better working relationships and reducing misunderstanding or prejudice. That makes their own

⁵¹ I have not investigated which companies or what exactly the details of cover are but it certainly is believed by the GPs themselves that they are not to become involved ‘in any way’ with intranatal care. Independent verification is beyond the remit of this study but seems not unlikely given the response of the INO insurers to withdraw private midwifery cover for home birth and the inception of the MOU. There is extreme reluctance on the part of insurers to accept any liability for the potentially expensive compensation for birth injury.

job and practice easier and, perhaps more importantly, some would argue, it should make the care pathway of the individual women choosing home birth easier.⁵² It also serves to make home birth more visible, potentially less threatening or bizarre and can be interpreted as a broader political action endorsing and promoting home birth as an acceptable choice for the general population. It is postulated that it is harder for people to demonise home birth practitioners if they have met them and communicated person to person before a formal working relationship is needed; a relationship that must work smoothly in potentially high stress situations such as hospital transfer for fetal distress.

Public Health Nurses

The midwives' relationship with public health nurses (PHNs), to whom they must send their intention to practice midwifery, has already been mentioned in the introductory chapter 'situating midwifery'. The PHNs have signalled that they feel it no longer appropriate that they should supervise midwifery practice (Institute of Community Health Nursing 2007 and Commission on Nursing 1998) and they effectively no longer carry out this function. Independent midwives and PHNs do however have a good working relationship as the midwife hands over continuing community care of the mother and infant.

Many midwives will formally write to the woman's GP about planned home birth requesting their support for routine blood tests and postnatal follow up for mother and the child. Some make formal telephone contact with the GP, the PHN and the hospital out patient department post delivery so that all know of the outcome. This could be seen as politically astute, by maintaining good relationships. It also ensures that they each hear about the good outcomes of home birth and sound independent midwifery practice which may counter horror stories of compromised babies or still birth.⁵³

During the ethnography I have heard of several places where PHNs are 'quietly' doing home births (p2L35 Diary 13Oct06) as was envisaged in the original PHN contract

⁵² In my own experience however and of the mothers I have worked with, drawing attention to the choice to home birth can still invite opprobrium from hospital obstetricians.

⁵³ Again it is beyond the scope of this study but the power of narrative, anecdote and 'horror stories' is socially very significant. They may not be considered good 'evidence' but they have great power. Junior or trainee doctors' experiences in hospital are usually of the abnormal despite most deliveries, even in hospital, being very normal.

developed in the 1960s (Higgins 2007). A paper published by PHNs Mulcahy and Dempsey (1999) arose from their facilitation of several home births in their practice area, and demonstrates that until recently at least, home birth was as accepted part of PHN practice though now it is very unusual.

Complementary therapists

Independent midwives are very open to women using alternative therapies and consulting alternative therapists. Just to give a flavour of the range, I will list those I have seen being used or heard cited by women and midwives in the few years I have been in the field: homeopathy, herbalism, acupuncture, acupressure and reflexology, cranio-sacral and regular osteopathy, Reiki and Shiatsu massage, yoga of many varieties, pilates, hypnosis, visualisation, couples' counselling, aroma, aqua, music and art therapies. Complementary therapists place an emphasis on holism compared to the vocabulary of specificity in mainstream allopathic medicine. Their focus on holism and individuality can be attractive to women seeking alternative models of care. Midwives are constrained somewhat in relation to alternative therapies as ABA guidelines preclude their use of therapies unless formally educated in their use (ABA Guidelines to Midwives 2001 section 17). Many independent midwives are also qualified complementary therapists with at least one homoeopathist and one shiatsu massage therapist amongst their number.

There are two distinct issues that affect independent midwifery discourse about complementary therapies. The first is the contested nature of some therapies, for example homeopathy. The medical or scientific establishment, do not accept that it has any proven efficacy. Very many independent midwives have a familiarity with homeopathy as a therapeutic measure in pregnancy and labour. Some midwives however draw on allopathic medicine's dismissal of homeopathy by arguing 'well there's supposed to be nothing in it anyway, so what's the harm?' Other therapies such as hypnosis, manipulative therapies like chiropractic, shiatsu massage, or acupuncture, have growing scientific recognition, if lacking a western rationalist explanation. Furthermore others therapies like herbalism or dietary supplements may have pharmacologic effects but their

use challenges the jurisdiction of state sanctioned pharmaceutical practice and medical diagnosis and prescription.

The second issue about acceptance of alternative or complementary therapies is not about the therapies themselves, but rather the whole idea of holism and support of the mother's health belief system. The woman's life experience within her social network, includes her personal acceptance or rejection of alternative therapies. Very often she has chosen to reject the medical model, its knowledge limitations and exclusions, and has sought other approaches to health and wellbeing. Many home birthers defy orthodoxy and choose not to vaccinate their children. Some extend this unorthodoxy and self reliance to home schooling of their children. The independent midwife, taking all these personal factors into consideration, will see her own role as midwife support as becoming integrated into the woman's own health model. Home birth, in common parlance, has itself become an alternative life style choice. It is not automatic that women (or midwives) will embrace all 'alternatives' but there is some considerable sympathy for perspectives on health that are beyond the mainstream.

This willingness of some independent midwives to accept, even to promote, some of the above therapies (though some midwives also doubt there is any evidence to support some of them, and question their use) may open their other midwifery practices and their grasp of the research evidence to critique by their detractors as 'witchery' or superstition; these are allegations and associations from centuries before. Whether it is the women or the midwives who are more inclined to alternative therapies is difficult to gauge. Many midwives seem to have working relationships with others in the alternative therapeutic field, for example homoeopaths, herbalists, acupuncturists or osteopaths. The midwives consult or suggest consultation with them for a variety of common pregnancy and neonatal conditions which are often not amenable to easy or successful treatment by allopathic medicine. Pelvic arthropathy, nausea, anxiety, bruising, oedema, breast feeding difficulties and unsettled infants are just some of many less contentious examples. Other conditions like anaemia, hypertension or bleeding have been so effectively construed as within the purview and legitimate control of allopathic medicine, that they are rarely

presented by the midwives as exemplars of the expertise of other therapies. Is it that other therapies cannot manage or ease these conditions? Or could it be that the reaction of the medical establishment to defend their absolute right to expertise and management of these conditions that to suggest alternative management would draw too much opprobrium upon the practitioner or midwife so that they choose not publicise the fact ? I suspect the latter, and yet am not inclined to dwell too closely on this point for fear of offering anti-home birth discourses the opportunity to associate independent midwifery with other unorthodoxies and unacceptable practices.

‘biomedicine enjoys a dominant status over heterodox and ethnomedical practices. This dominant status is legitimized by laws which give biomedicine a monopoly over certain medical practices, and limits or prohibits the practice of other types of healers.’ (Baer, Singer and Johnsen 1986:96)

The use of scientific discourse in the professional closure strategies of western allopathic medicine is very powerful. Its power is certainly recognised and apparently accepted by most if not all independent midwives.

It is not only a familiarity or comfort with complementary therapies that exemplifies independent midwives but also a concern for optimal health through diet and exercise. All midwives exhort a healthy dietary intake and lifestyle, but some put particular emphasis upon micro-nutrient intake, avoidance of environmental toxins and promote organically farmed produce. Environmentalism, in rhetoric, in demonstrated behaviour and even by activism is not uncommon amongst independent midwives. Similarly a sympathy with, or practicing vegetarianism or veganism is not unusual. There is a notable consistency between ecologically friendly lifestyle choices and the idea of holism in midwifery practice.

Many midwives find themselves caricatured as ‘brown rice and sandals, knit your own yoghurt, hippy dippy types’. This stereotype is difficult to dislodge because there is some truth in it. It can explain why, in their dealings with health authorities and other professions, midwives play up their socially and professionally acceptable characteristics such as the evidence base for their practice, their client focus, their quality-enhancing attributes, their efficiency and cost effectiveness. It may explain also why they play down the more difficult to quantify elements of warmth, relationship and holism when they are

presenting themselves to external agents (such as me in my researcher role). During the ethnography I found that despite the prevalence of intuition and spirituality as topics of concern in the midwifery literature, very few of the midwives spontaneously mentioned these aspects to me. When I pressed them they did articulate something of their perspective on these topics. These would benefit from a more in-depth and focused study of midwifery experience and interpretation of meanings but as they did not present themselves as central themes I will address them only briefly. I have to acknowledge that my biography especially my role as midwife teacher and researcher may have inhibited talk in these areas. It might have been assumed that I have a commitment to hard scientific evidence and objectivity arising from the teaching and researching role and perhaps even from assumptions about gender and rationality.

Broader social / maternity interest groups

The Home Birth Association (HBA) provides a very useful function for independent midwives in that it maintains a website giving much information and advice for women seeking home birth in Ireland. They also maintain on the site a list of contact addresses and phone numbers for independent home birth midwives and refer requests for home birth to those midwives. They send copies of their magazine and invite midwives to attend their annual conference where each year, as part of the conference presentations, parents tell their own home birth stories. The HBA forms a vital link between midwives offering and women seeking home birth. Word of mouth recommendation between women is a great comfort to many women seeking the services of a midwife.

The Association for Improvement of Maternity Services (AIMS) a UK-based organisation has, since 2007, once more had an Irish branch (AIMS Ireland). Cuidiu (The Irish Childbirth Trust) has developed a Consumer Guide to Maternity Services in Ireland (Cuidiu 1999) in collaboration with the Health Promotion Unit of the Department of Health and Children. Individual independent midwives have been closely involved with the work of each of these organisations and in many other smaller and more local initiatives around birth and maternity services liaison and activism.

This section then has discussed working relationships between the independent midwives and other professionals within the maternity services and with other therapists and birth

interest groups. Relationships between independent midwives are the focus of the next section.

Section three Day to day relationships between independent midwives: Collegiality or Isolation?

To paint a picture of independent midwives as completely isolated from the world of midwifery practice or education would be a misrepresentation. In their day to day practice however, most independent midwives do work alone, and, when it comes to supporting women in labour and delivery are most likely to practice without the presence of a second midwife. Notable exceptions to this are the midwives who work within the Cork and Kerry home birth scheme where generally though not always, a second midwife is in attendance. Therefore, after some discussion on the experience of working alone as an independent midwife, the particularities and significant differences of the Cork scheme in this regard will be considered. The midwives during the period of the ethnography were threatened with withdrawal of clinical indemnity insurance and so became involved in negotiations between their union (the Irish Nurses Organisation, INO) and with the HSE as part of the Domiciliary Birth Implementation Group (DBIG). The DBIG negotiations and development of a memorandum of understanding (MOU) between the HSE and the independent midwives will be considered towards the end of this section. The section, and chapter, will close with a discussion of the emergence of a professional body for independent midwives, the Community Midwives Association (CMA).

Working alone

All of the midwives feel it is the one-to-one nature of the mother midwife relationship that is central to the women's and their own satisfaction. Therefore they / we guard that relationship quite jealously. In the years I have been practicing independently, I have come to value the intimacy between the couple (for they are usually a couple) and myself. It is central to my philosophy about birth that it is the woman herself who delivers the baby; she takes all the decisions about her and the baby's care from pregnancy to parenthood. When I practice midwifery alone however, the difference I make to her experience, I make based upon my own skills and resources. To have succeeded, to have supported a woman to, and through, a positive birth is very powerful; it brings a very

personal affirmation and sense of pride. When there has been a second person present at delivery, I have noticed that this extra person changes the dynamic in the home. The interaction and relationship with the woman indeed with both parents changes; it is more diluted and more self-conscious. I have therefore to acknowledge the temptation to practicing on my own. This perhaps indicates that there are other reasons for isolated rather than shared practice than simple geographical isolation.

Nonetheless isolated practice has its distinct disadvantages. One independent midwife, echoing my own sentiments and that of many others says ‘One of the key things that makes independent midwifery difficult, is isolation and lack of support; that you are very much on your own’ (p2L34 FN11Mar07).

During this ethnography, it became clear that many of the independent midwives had never met each other. Very often they knew, or had heard of other midwives through their names appearing on the HBA website, or social encounters over the years, usually at a home birth conference or at various midwifery events. Some, however, have worked more closely with each other professionally, attending the same woman at her birth, or occasionally sharing some aspect of ante or postnatal care. One pair of midwives, who worked closely together for a period in Galway, have acted with more formal professional support to each other, to the point of submitting shared audit of their practice for some years of their working together.

A second midwife

While most independent midwives in Ireland work alone, there is awareness amongst them that attendance at birth as the sole birth attendant is less than ideal and is, for some, an uncomfortable position to occupy. If there should be a complication during or immediately after birth, for example, and the woman is bleeding or the baby needs resuscitation, then the midwife’s attention is taken from the other. In a worst case scenario, both mother and baby may demand her urgent attention simultaneously. Independent midwives all express some degree of concern that this situation might arise and in their rhetoric explain that they know that a second midwife should be present. In most of the country however, having a second midwife is not possible. They argue that there are so few midwives and their already very busy schedules make such doubling up

unrealistic. Several midwives do however pair up, especially in the Cork scheme region which will be discussed below. The timing or estimation of labour duration can be tricky and so the second midwife may be there for only a few minutes or for several hours of labour.

The great advantage of having another midwife or several midwives working together is not only that there can be two at a birth, but that it is possible for them to negotiate to 'cover' for each other for social functions and holidays periods that are described as being problematic for so many midwives working on their own. The direct one-to-one relationship of a very well known midwife attending delivery can however be compromised somewhat by the presence of another, but the second midwife and the mother are likely at least to have met and have some mutual familiarity. Some mothers would prefer a single midwife to attend and thus have as few extra people at the birth as possible. The compromise from that ideal may be compensated by the arguably greater good of having a model of care where two midwives who can be assured of reasonably protected time off and therefore avoid burnout and remain available to more women.

Burnout and sustainability

Cecilia Benoit (1987) talks of the 'uneasy partnership' between mothers and midwives and several authors have suggested that there may be the potential for the exploitation of midwives by their clients (Annandale and Clark 1996, and Sandall et al 2001).

Some independent midwives speak about women not appreciating the costs to them of the contract to care. I would like to retell one story here. I was with a midwife in her car travelling between antenatal and postnatal visits when she received a phone call and pulled over. It became clear from the half conversation that I was hearing that the woman was querying the cost of midwifery services and the midwife was obviously finding this upsetting. I felt this was an intrusion, an unexpected and therefore uninvited observation of 'real life'. I was torn, briefly, between ethnographic observation, and social discretion, respect, and ethical qualms. I decided to step out of the car. The conversation continued for about ten minutes and the midwife was visibly upset and crying. Later she talked about the conversation and it became clear that what upset her was that the relationship of closeness, trust and perceived friendship was a vulnerable entity, which had been

damaged by financial considerations. If the midwife did not value the relationship, the negotiation of finances should not have been distressing. Several aspects of relationship are revealed here. The first is that the sense of a familiar and caring relationship was real to her. Secondly, such a relationship was valuable and valued, and thirdly that relationship was damaged in the contestation over payment. She spoke of feeling personally devalued or undervalued and of feeling foolish for giving so much and for putting herself out. Her caution to me was to be very clear about the financial and contractual details at the outset of the relationship. It was not however a caution against forming close and personal relationships with women.

Very many of the midwives I worked with and interviewed, have mentioned team midwifery, or pairing with another midwife, as key to avoiding burnout and emotional and physical exhaustion in independent midwifery practice.

A low sense of personal accomplishment at work, and dehumanisation of clients, in combination with emotional exhaustion, has been described by Maslach & Jackson (1986) as burnout. Jane Sandall (1997) in her study comparing different models of team midwifery found very different degrees of burnout between different midwifery models of care. Although in the very different context of team midwifery, the UK National Health Service (NHS), and an urban London setting, she identified three key themes to sustainable practice in community midwifery. They were occupational autonomy, social support from colleagues, and the ability to form meaningful relationships with women.

Independent midwives have some of these protective attributes. They have for example significant freedom with regard to managing their own time and workload. The independent midwives also describe deriving considerable satisfaction from their relationships with women, so these are factors that would seem to support the sustainability of the independent model. The almost incessant nature of on call work, and the high degree of emotional engagement they report, is nonetheless decidedly more arduous for the lone independent midwife.

‘There is a danger that the independent caseload model – an ideology arising from a profession aiming to increase its autonomy and sphere of practice – may lead down a path of unsustainable practice.’ (Sandall et al 2001:135)

The lack of social and professional support from colleagues is perhaps the most significant deficiency for most independent midwives practicing in Ireland.

Several of the independent midwives express concern that unsupported one-to-one midwifery practice is unsustainable in the long run. Several of the midwives in the Cork scheme, which requires and facilitates a second on call or support midwife, have said that they could not have maintained their practice without the support of the service coordinators but more explicitly, without the close physical and emotional support of their colleagues in their everyday practice. While midwives enjoy their work and value their relationship, an unsupported practice model puts the sustainability of independent midwifery in the long term in some considerable doubt.

Collegial support

During the ethnography I found that the midwives do speak to and support each other usually by mobile phone conversations and texts. Each seems to have one or two other independent midwives with whom they say they have a closer relationship. They use them to bounce off thoughts and concerns regarding their midwifery practice or particular aspects of a mother’s history, or complicated professional decisions (p1L12 FN 08May07 p12L10 FN 20Nov06). Still others make no mention of such a relationship. Others report maintaining connections with midwifery colleagues in the UK in particular where they can talk of professional concerns (p6L12 FN21Oct07).

Informal telephone conversation about a case, whether in pregnancy or the post partum period, but particularly perhaps during labour has been, to me, a considerable comfort and source of professional support as an independent midwife.⁵⁴ Others too talk of the

⁵⁴ The mobile phone was mentioned as a resource by several current and former independents who recall the time when land lines were the only communication available. They speak of a time when ‘bleeps’ were used to make initial contact and where partners or the midwives themselves had to go to the nearest phone box (which might have been some distance away) before woman-to-midwife contact could be made. This technology, and others such as email, has made communication and thus collegial support between midwives much easier than had previously been the case. The other logistical factor contributing to

significance of having a fellow independent midwife who is willing and able to listen and advise in awkward situations. In telling of these instances of support the midwives clarify that each midwife is autonomous and fully responsible for her own practice. In articulating the situation, their concerns and their already planned course of action, they are able to reassure themselves that they are 'on the right track' have 'covered all the options' or 'are making the right decision'. So professional support is sought and valued by the midwives and on these occasions they are acting as consultants to each other. This professional collegiality however is, by necessity, *ad hoc*. This is not a criticism; it seems to be the most appropriate mechanism for obtaining suitable and timely support.

Post hoc discussion and reassurances may also be part of this professional support, but also simply knowing that someone else knows or cares about one's dilemmas or successes by way of a congratulatory or sympathetic text is very highly valued by otherwise isolated individuals.

I would like to make one small further observation. Midwives' readiness to explain that the contacts between each other is not a derogation of their professional responsibilities, their autonomy or their accountability is, I feel, a signal (one of many I will explore in the section on professionalism) of their anxiety to present a fully professional front and not to have their professionalism impugned. It seems to me that they, and I, as a direct consequence of professional isolation, experience a diffused disapproval, and a suspicion from others. It is as if working outside the immediate embrace of the normative structures of hospital practice where professional colleagues have their own norms, is a breach of etiquette, and therefore is somehow improper. Independent midwives seem to be constantly seeking to ingratiate ourselves to protect against that inchoate disapproval.

Cork home birth scheme

The Cork home birth scheme is an unusual exception to the general rule that independent midwives work alone. There are several unique elements of practice in this region that make the midwives practicing in this model rather different from the others in Ireland and

midwifery isolation is geography. Their relative dispersal across the country and the need to travel, often considerable distances, is a hindrance should they want to meet or to act as second midwife to each other.

so they will be outlined here. Their experience otherwise shares much in common with the other midwives and theirs are incorporated within other analyses.

The scheme is made up of eight midwives, three near Cork city, three in more rural west Cork and two in Kerry. There is a HSE-employed midwifery co-ordinator based in Cork that administers the scheme. She takes home birth requests, liaises with women, sends out birth packs, visits mothers' homes, acts as supply and equipment resource for the midwives, liaises with the maternity hospitals, and facilitates practice updating, and peer review as well as administering a steering / review group. She also administers documentation, statistics and direct payment of the midwives through the HSE southern area schedule of payments. This service, and these functions, support the work of this group of midwives (comprising approximately 50% of the independent midwives in Ireland) in a way that is not available to the midwives practicing elsewhere. The terms of the scheme also explicitly encourage the attendance at birth of two midwives. In the case of primigravid labour or slow multigravid labour this is often achieved. While support or 'second on call' can be from any of the other midwives on the scheme, in practice the two Kerry and two of the Cork midwives tend to work as stable pairs and thus have the added support of having their partner available to 'cover' for them for holidays or other social or professional events. This degree of freedom for other commitments is not usual elsewhere, though independent midwives in other areas do tell of informal working partnerships at times but not on a regular basis.

One Cork midwife who had worked in a team setting in the UK reported that if it were not for her close working relationship with another in the Cork scheme she 'would have been burnt out years ago' (p6L12 FN 30Nov06 and p9L8 FN 20Nov06).

The sense of security of having a second opinion is a constant theme between midwives who operate in this system (p18L5 FN 20Nov06).

Some of the Cork midwives are very positive about their shared steering group peer review meetings, reporting that there is a good opportunity to discuss aspects of cases that they find 'tricky' for various reasons and for them to talk about management decisions (p5L31 FN 29Sept 08). Others are very keen that the independent midwives attempt to form a professional organisation (p17L6 Diary 26Oct07).

The Domiciliary Birth Implementation Group

In 2004 the Domiciliary Births Group Report to the Chief Executive Officers of the Health Boards (DBG 2004:97) had recommended the establishment of a national implementation committee. In 2007 when the INO threatened withdrawal of insurance, this group had still not been appointed nor convened. (See chapter nine for a separate discussion of clinical indemnity, particularly relating to home birth midwifery.) A committee, called the Domiciliary Birth Implementation Group (DBIG) was convened under the chair of Gretta Crowley a local health officer (LHO) in the Cork region. The Cork Home Birth scheme (discussed above) had been the only domiciliary / home birth pilot that was funded from the community budget (Primary Continuing and Community Care PCCC) rather than from the acute hospital sector of the HSE. The original domiciliary births group had had an independent midwife from the Cork scheme as a member. Her campaigning presence on that original group and health service policy to promote stakeholder participation in health service planning (Department of Health and Children 2001a) ensured that on the DBIG there were both user representatives and independent midwives. Four independent midwives, one each from Cork, Kerry, Galway and Dublin, were invited to serve on four subcommittees. I was one of them.

The urgency of the midwifery insurance issue was the main focus of the DBIG. The HSE was reluctant to directly employ independent midwives. They would then have responsibilities as employers that they were unwilling to accept. The decision was made that the midwives would be contracted to provide home birth services under a memorandum of understanding (MOU) with the HSE which outlined the conditions by which a contract for payment and indemnification under the State Claims Agency, clinical indemnity scheme (SCA, CIS) would apply. The MOU allowed the direct payment of midwives by the HSE (rather than by grants to the mothers, as previously) and indemnified their practice. This was quite a remarkable decision as it gave HSE legitimacy for independent midwife attended home birth to the whole country (albeit with some considerable restrictions). The indemnification focus and the immediate winding up of the DBIG after the development of the MOU between the HSE and the independent midwives, was deeply unsatisfactory to most on the DBIG. This was because it addressed none of the rest of the proposals from the 2004 report which included proposals for a

nationwide community midwifery service and considered aspects of midwifery regulation including midwifery prescription. It did not satisfy hospital representatives because of the lack of integration between the hospitals and independent community midwives and the lack of clarity about their governance relationships. Furthermore, the public health nurses, who had at one time been charged with the supervision of midwives in the community, no longer feel it within their professional scope of practice to supervise midwifery practice (see chapter one, page 32 and chapter eleven, page 301).

The main issue with regard to insurance and midwifery autonomy (and women's birthing autonomy) is that restricted criteria of 'suitability' were attached to the MOU. Thus independent midwives remain caught in a dilemma; what are they to do for women who fall outside the MOU criteria? Should they decline to attend them or attend them without insurance? The midwife will be aware that those women who fall outside the MOU criteria are, at least within professional obstetric orthodoxy, higher risk. If the midwife should have to defend her practice, she has taken on to attend someone whom other professionals (obstetricians) and the majority of their own profession, and now many of their own direct peers, would not attend for a home birth. Her vulnerability in these cases has been increased rather than decreased. (Consideration of this and other midwifery dilemmas will continue in chapter eight.) One of the major flaws of the MOU is that it does not address the issue of women wanting home birth who do not fit its eligibility criteria.⁵⁵

At the time of writing (August 2009) there is no national domiciliary birth group, nor for the Dublin North East and Dublin Mid-Leinster regions. There is however one in the west

⁵⁵ Interestingly, since the introduction of the MOU between independent midwives and the HSE in 2008. The 'Home Birth Contrary to Midwifery and Medical advice' form, no longer arrives with the HSE home birth documentation. The MOU thus no longer admits or accommodates that women (and midwives) may birth outside their 'suitability criteria'. The old (pre 2008) HSE form (Southern Board) contained the wording: 'This is to certify that I, the undersigned having had the risks associated with this home birth, explained to me by the midwife and understanding these risks, *insist* on having a home confinement *contrary* to Midwifery and Medical advice and against the wishes of the Southern Health Board.' Both '*insist*' and '*contrary*' were highlighted in red ink in this original document. A copy of the contrary to advice form is included in appendix four. Note too that while the parent is not obliged to sign any refusal form, the existence of such a form normativises compliance and highlights the parents deviancy. Furthermore seeking signed refusal puts the professional, who is obliged by that same professional status to explain and administer 'best practice', in the position of wielding (or being asked to wield) professional power and knowledge at exactly the point where the woman wishes to exercise her autonomy. This is another example of where the 'ordinariness of the day to day' reveals the structures and processes of power in the context of independent midwifery.

coast region and the Southern region, Cork scheme review group remains.⁵⁶ The original MOU is due for renewal in September 2009. Without regional groups or a national body there is little or no mechanism for developing the current MOU which restricts the autonomy of midwives, and fails to provide an equitable and accessible service to all women in the country. The HSE have proposed (since 2007) to set up an expert advisory group (EAG) on maternity services, but that group remains unappointed and, which is a point of concern for home birth advocates, will not have domiciliary maternity services as its focus. It will therefore likely be dominated by concerns from the much larger acute hospital sector.

The CMA, the birth of a professional body?

Independent midwives have in the past gathered together in an ad hoc manner to comment on issues in common. Examples include responding to a proposal in 1998 that direct entry midwifery students get community experience with independent midwives (Carroll and Begley 2003); making submissions to Commission on Nursing Document (DoH&C 1998, Independent Midwives (Irl.) 1998); discussions on submissions to proposed changes to the Nurses and Midwives Bill in 2007; petitioning their union, the Irish Nurses Organisation (INO) and the HSE about the withdrawal of their indemnity insurance also in 2007.

Several of the midwives have spoken of attempts in the past to set up an independent midwifery association but that these attempts had fallen apart, either through personality differences or the pressures of time and distance. The shared vision or unifying purpose of projects which gathered them together in the past had been insufficient to cohere them enough to form a more stable arrangement and allow development of a professional body. With the Cork scheme as a general exception, and other occasional exceptions, independent midwives have therefore, by necessity or inclination, to work alone. They have to be self-motivated and proactive in liaison with various agencies, the HSE, maternity hospitals, GPs, PHNs, pharmacists and equipment suppliers. They also need to administer and document their practice, publicise and update themselves, and

⁵⁶ At time of publication (January 2010) this steering group had been disbanded pending regional restructuring.

communicate with professional and statutory bodies. Having no distinct collective or governing body makes 'being heard' problematic, both for governmental and professional agencies, and for the independent midwives themselves. Accessing an 'opinion' or 'representation' for state agencies or media is at best 'hit and miss' and at worst impossible. All this makes independent midwifery issues well nigh invisible.

Arising from their combined interest in indemnification and their representation on the DBIG, the independent midwives recognised, once again, the need to work more closely together. The Community Midwives Association (CMA) was proposed and initial meetings were arranged. This has been the first concerted effort by the independent midwives to convene as a professional body.

The unusual case of the pair of midwives, who submitted shared audit of their practice in the late 1990s, has been reported above. The Cork scheme too has produced a report of its activities as part of the pilot evaluation. A similar audit of independent midwifery practice is currently being discussed by the nascent CMA as a means of demonstrating what they actually do. The CMA has produced a booklet 'Midwifery Standards Review' (2009) which contains a pro forma for a review process. This is proposed as part of a model of peer practice review that would promote quality assurance amongst its independent midwifery membership. The CMA recognise that they should take control of such a process themselves rather than face having another mechanism imposed upon them by non-domiciliary midwives or, worse again, non-midwives or obstetricians. While independent midwives have expressed an interest in peer review, they have avoided the word supervision (p16L6 Int 18Sept08, p15L24 Int 11Jul08). The lack of a supervisory structure for midwives in Ireland has been outlined in the introduction chapter. Supervision will be revisited in the final chapters of this thesis as it has relevance to the concept of professional autonomy which recurs as a central motif in independent midwifery practice.

Mary Douglas (1966) has written about the difficulty that communitarian groups may have in negotiating stability and avoiding splintering due to strongly held philosophical

or ideological differences between individuals. The CMA is very much in this delicate formative stage where negotiation of norms is in process but where personal, ideological and philosophical differences within this very diverse and independently minded group, has a very real disruptive potential.

Summary

This chapter has outlined the major relationships that the midwife must maintain in her day to day practice. The primary relationship is with the woman she is attending. This relationship has been demonstrated to be close and personal. It has been demonstrated to be supportive of the mother and satisfying for the midwife. The importance of the relationship must not be underestimated for, as will be demonstrated in chapter six, it forms the foundation upon which the mother's birthing autonomy is built. The links between relationship and autonomy, between relationship and safety, (both chapter six) and between relationship and intuition (chapter five, section two, page 171) will each be considered.

The second section of this chapter demonstrated that there can be a tension in the relationship between independent midwives and orthodox hospital practitioners. It seems that that tension comes from the midwives' (and the mothers') philosophical commitment to holism, relationship and normality in birth which puts them at odds with an interventionist and risk-fixated emphasis on abnormality.

Despite antagonism from particular individuals and the general view that home birth is now unorthodox and counter cultural, independent midwives strive to maintain good working relationships with the mainstream maternity services. Given a history of antagonism to home birth, some midwives may have had limited contact with mainstream maternity services in the past. Though understandable, this only cultivates an atmosphere of suspicion between the mainstream and independent practice, and makes smooth transfer into hospital problematic. The difficulty of hospital transfer is explored more fully within chapter eight on midwifery dilemmas which expands on the relationship between independent midwives and hospital staff in that circumstance.

There is more than a small element of professionalization or occupational closure discourse in the contested ground between the obstetric and midwifery professions. These areas will be discussed much more fully later in the thesis, but it can be seen that at the professional relationship level, this tension becomes visible and independent midwives choose different strategies to address it.

Some midwives, accept homeopathic remedies and refer to these complementary practitioners, some even prescribe them and some use scientific discourse to argue their safety or even reject their rational use. Whatever their personal choice, there is certainly evidence that midwives are aware of the power relationships within Irish maternity services. They are aware too that their allegiances, even on this small matter, require careful presentation.

The third section has considered the relationships between independent midwives. Although they act as a resource for and support to each other, this support is not (other than in Cork) realised in formal working partnerships. That there are so few independent midwives and that they are geographically dispersed is cited as the main reason for this. Independent midwives acknowledge that having two midwives at every birth is good practice. It would be good for mothers and babies' safety, it would also be good for collegiality for preventing burnout and for professional defence should 'bad' outcomes occur. The independent midwives however seem to resist team models, perhaps because of their independent nature but also perhaps because of the very particular sense of pride in their ability to support women from their own resources. There is concern that by 'doubling up' they might reduce the number of women who could avail of home birth. Certainly in negotiations with the HSE in the domiciliary Birth Implementation Groups (DBIG) the midwives strongly, and successfully, advocated for making a second midwife a recommendation rather than a requirement, because inability to get a second midwife would certainly prevent many woman from having a home birth.

The CMA is an attempt to build a stable association of independent midwives to act as a professional support for each other. It is still very much in its formative stages but has already started to formalise processes for peer review and audit which should improve

transparency and demonstrate self governance to those who would resist independent midwifery as a means for providing home birth choice to the women of Ireland.

Chapter Five Discourses, pervasive and muted, in contemporary maternity services

This chapter examines some of the discourses that overlay the field of contemporary maternity services. The more dominant or pervasive discourses would appear to be contrary to the stance taken by independent midwifery in their philosophy of being with women and in their practice of that philosophy. The next chapters will examine autonomy and professionalization as key themes identified in the ethnography. This chapter is intended to ‘clear the air’ somewhat, by identifying the background discourses within which these two core concepts are positioned, and within which independent midwives must construct their own counter discourse.

The second part of this chapter presents two further discourses, which although they appear in contemporary international midwifery literature, seem to be significantly muted in the Irish midwifery context.

Section One Pervasive discourses in contemporary maternity services

A short exploration of the competing discourses that exist might help to understand how perspectives may differ, overlap, or align and so obstruct or smooth relationships between professional groups. Jo Murphy-Lawless’ book ‘Reading Birth and Death: A history of obstetric thinking’ (1998) explores all of the following in considerable depth, drawing from Irish hospital documents and Irish medical writings.

The discourses I would like to examine here are discourses on normal and abnormal in birth and the consequences for Midwifery in accepting normality as their professional jurisdiction. Discourses on risk pervade contemporary society and are particularly significant in maternity care. Murphy-Lawless (1998) points out the power of the risk / death pairing in obstetric discourses about birth. There is a significant overlap between these two discourses as they use the language of science as justificatory for their argumentation. Scientific knowledge has been examined by Foucault (1978) in his own explicit pairing of knowledge and power and this is visible within midwifery / obstetric discourses of risk and normality.

Two practices that are very significant to contemporary maternity services and which are strongly contested by independent midwives are institutionalisation of birth and the

increasing use of technological interventions in birth. The discourses underpinning these two practices, like the two previously, overlap with broader discourses in society. Society accepts technology and business efficiencies as incontrovertibly good, as part of the modernist grand narrative of 'progress'. So challenging them in birth culture is counter-cultural. Sociological writers such as Beck, Giddens and Lash (1994) and Bauman (1993, 2004) have critiqued modernity. They present a reflexive modernity that acknowledges the consequences of progress are never without cost. I do not intend to expand upon this debate except to demonstrate that the activities and philosophy of independent midwives are reflective of the contested nature of progress which is promulgated by the dominant forces and discourses in contemporary maternity care in Ireland.

Normal and Abnormal in childbirth

Foucault (1978) explored the link between the concepts of power and knowledge. Of relevance to this section on normality and abnormality is his concept of normativisation. Normativisation describes a side-effect of scientific measurement and description of normal distributions of populations. Measurement and surveillance presents facts about persons and populations but there is a tendency to make evaluative (moral) decisions about those descriptions. Thus Foucault identifies measurement and surveillance as techniques of power for they are used to make decisions about human values and determine human activities. This will be explored more fully in the section on professionalism and especially epistemic (knowledge) authority. I will move here to the contestation between normal and abnormal in maternity services, which underpins the professional claims of obstetrics and midwifery.

That midwives consider themselves to be experts in normality in childbirth remains a central motif in their rhetoric, their education and training. This is true whether they are practicing in hospital or in the community (Henderson and Jones 1997, Downe 2004, Page and McCandlish 2006). Midwives argue (rightly, Hatem et al 2008) that most pregnancies and births are unproblematic. They also argue (again correctly, Hatem et al 2008) that support by a qualified birth attendant (a midwife) improves outcomes. Further they accept that when abnormality arises, sometimes specialised intervention beyond their skills, scope (and statutory remit) is necessary. It is the precise identification of

abnormality, how it is defined, and by whom, that has been the ground of contestation between obstetrics and midwifery since even before the statutory recognition of midwifery in Britain (1902) and Ireland (1918). Those who discuss professionalism and professionalization (see chapter seven for fuller exploration of these terms and their differentiation) talk about the concept of professional (or occupational) closure which is the mechanism of identification and effective closing off the jurisdictions between competing professions / occupations. It is perhaps more often seen in the delineation of sub-specialisms within an occupation.⁵⁷

The normal / abnormal divide in childbirth seemed to protect the midwife from further usurpation by the medical / obstetric profession by securing their professional autonomy (Witz 1992). Other structural factors, not least the make up of the regulatory bodies for midwifery and subsequently the ABA (see McMahon 2000, Matthews 2006 and Higgins 2007), and the institutionalisation of birth, and the hierarchical structures within institutions all undermined midwifery's position. Continuous expansionist discourses of medical / obstetric professional closure have further co-opted the normal abnormal distinction to their own purposes. The classic discourse in this regard is the argument that no birth can be considered normal except in retrospect (Percival 1970). The 'potential' for abnormality thus became the limits / closure point for abnormality and the jurisdiction for obstetrics. Elizabeth Nihell (1790) (cited by Murphy-Lawless 1998) gives a very early critique of the argumentation which effectively places birth solely within the obstetric purview. Independent midwives continue to emphasise their expertise in normal birth and to critique the high levels of intervention in birth which they, not unfairly, lay at the door of obstetric practices. What seems to be absent but which may begin to emerge from

⁵⁷ Specialisation has itself been identified as a means of raising the status of cadres within professions (Hugman 1991, Hughes 2006). This has particular significance for midwifery because clinical nurse specialism and advanced nurse practitioners have been proposed and accepted as means of procuring a clinical promotional structure for nursing. This follows to an extent the model for medicine. Midwifery however, at least in relation to the development of the advanced midwifery practitioner role in Ireland, has argued against the appropriateness of such a means for midwifery (Begley et al 2007). Midwifery is a holistic and therefore a generalist profession. Midwives already critique the compartmentalisation of care that happens in hospital institutions and reject that compartmentalisation (into antenatal intranatal and postnatal care) is appropriate for women of for midwifery. Midwives argue too that specialism further divides and undermines the holistic principle and too readily follows and becomes co-opted into the already overly medicalised model of maternity care.

independent midwifery discourse and practice is an alternative and midwifery-expanding discourse.

The normal / abnormal discourse, as a means of closure between obstetrics and midwifery, has thus been overlaid by obstetric co-option of the normal. Midwives need to find ways to articulate a powerful counter-discourse to reclaim midwifery legitimacy in normality. They also need to expand the boundaries of normality. Midwives might consider utilising their already acknowledged ability to identify abnormality as means for recolonising naturally occurring, but now categorised as abnormal, conditions such as breech presentation and twin pregnancy. It is by no means philosophically unreasonable or inconsistent for midwives to 'own' all birth processes up to surgical intervention (and even elements of that have been willingly devolved to midwives eg. intravenous cannulation, episiotomy, perineal suturing and, outside Ireland, venthouse delivery). Midwives in Ireland have not articulated this claim nor has it gained popular momentum elsewhere. Midwives have chosen instead to articulate a more humane set of birth practices predicated upon relationship and birthing autonomy. Such moves less directly challenge the bastions of obstetric power. The same humane birth discourse has been successfully co-opted by obstetrics with 'home from home' initiatives in hospital, and private continuity of consultant care, being models that pre-empt midwifery and indeed the need for the midwifery profession at all.

How are we to regain focus on the mother rather than on the structures or procedures that ostensibly serve her? This philosophical opposition between the normative power of science which underpins professionalism, and the individual personal relationship which underpins midwifery belief in women's power to birth, emerges repeatedly and in many guises in this ethnography. I will signal its recurrence because it becomes, in the final analysis, the overarching theme that pervades the independent midwifery experience. The discourses of professionalism and birthing autonomy will be examined more fully. The tension between them that has been detected by other writers will be outlined. The unique context of home birth midwifery in Ireland brings them into sharp opposition and demands further examination of where and how the discourses cut across each other.

Technology and birth ⁵⁸

The modernist vision is that science and technology can always be used to improve the quality of human existence. In this vision, more is better. Various critiques of this position exist, notably in the writings of Beck (1992, 1999) Beck, Lash and Giddens (1994) Bauman (1993, 2004). Rather than simply deny the grand narrative of progress as do the postmodernists, these authors examine the reflexivity of modern society and identify that the unseen consequences of putative progress invariably fold back and temper modernity's idealistic vision. The influence of scientific progress and technology in birth is similarly contested with many examples available of their negative consequences on women's experience of birth. The CTG (cardiotocograph) used for continuous fetal monitoring in labour has not, as had been hoped, improved perinatal outcomes but has instead increased enormously the rate of caesarean section and other interventions in labour. Increased diagnostic power has over-layered the debate on normality and abnormality mentioned above by increasing the number of pregnancies, babies and women characterised as abnormal and as needing further interventions to maintain their 'safety'. (See also the section on risk discourse, below.) Marsden Wagner in his book *Pursuing the Birth Machine* (1994) questions the appropriateness of a 'more is better' approach to birth technology. His writings, as well as those of Wendy Savage (2007) and many others, demonstrate that critique of maternity services is well embedded in the profession of obstetrics and is not solely of concern to women and midwives. As Perkins (2004) points out:

'excessive intervention is in large part a middle- and upper-class issue. The other side of the (same) coin is a seriously inequitable access to medical care and inadequate intervention levels for some populations. (Perkins 2004:10)

Perkins also examines the business nature of maternity services which further complicates and disenfranchises women's maternity care choices. This consideration is however beyond the scope of the present section. Jordan (1987) examines the symbolism of technological artefacts in American hospitals and demonstrates that increasing technology decreases accessibility of physical support, and devalues women's knowledge

⁵⁸ The use of technology in professionalization is also discussed in chapter seven.

of their bodies and control over their birth. And yet Sawicki (1991:85) acknowledges that ‘part of the attraction of the new technologies is that many women perceive them as enabling.’ In the context where other elements of personal and social control are diminished, this is not a surprise but does not address the underlying social mechanisms that induce fear of childbirth and heightened perceptions of risk rampant within institutionalised obstetric (and midwifery) settings. What is important in relation to midwifery and obstetrics contestation over technology and childbirth is highlighted in the following two quotes:

‘Effective forms of technology increase possibilities for human intervention in reproduction, they create the opportunities for greater power in the hands of whoever controls the technology.’ (Sherwin 1992:119)

and

‘Whether or not the technology is superior, it takes power to maintain a monopoly over it.’ (Katz Rothman 1991:76)

It could be that midwifery’s resistance to technology is simply that midwives are not in the position to wrest the power of technology from the hands of the obstetricians. They might want to wield that technological power over women themselves. Midwives are hardly likely to admit that were it so, nor to see themselves as likely to do so (Sinclair 2006). Notwithstanding the possibility of either of these alternative readings, my interpretation (admittedly as a midwife myself) is that midwives recognise that it is the taking of power away from women (rather than giving it to them) that is the greatest danger of increasing technological intervention in pregnancy and birth.

Kirkham (1998) writes about technology as undermining the mother-midwife relationship. In Ireland, Abbey Hyde and Bernie Roche-Reid (2004) in their interviews with 12 midwives, found that within the hospital setting, facilitation of the autonomous life choices of women was impeded by the technocratic system of obstetrics.

Davis-Floyd and Mather (2002) describe the technocratic model of birth as being the dominant model in western institutionalised birth settings and propose two others, the humanistic and the holistic as alternative models, that more closely reflect midwifery and independent midwifery home birth models.

Midwives who believe in promoting birth without intervention are vulnerable to attack because of the carefully nurtured link between technological rationality (Marcuse) and medicine.

‘Recognizing the power of science in modern society, midwives face the challenge of becoming more ‘scientific’ without necessarily becoming more technological.’ (DeVries and Barroso 1997:261)

and

‘the consequent debates over whether new technology should or should not be employed weaken the image of the [midwifery] profession in the eyes of a public convinced of the value of technology.’ (DeVries and Barroso 1997:262)

This reification of technology is another of the many cross-cutting discourses that maintains midwifery in a lower status position with regard to medicine and which is a concern for midwifery professionalisation (see chapters seven and ten). More importantly, at least to a midwifery rhetoric of support for birthing autonomy and midwifery as ‘being with women’, technology and its uses are potentially damaging to mothers’ and baby safety.

‘As these medical disciplines isolate specific types of abnormality or deviancy, they construct new norms of healthy and responsible motherhood.’ (Sawicki 1991:84)

Commitment to the technological-fix undermines safety by introducing unnecessary intervention but also by undermining women’s confidence in their own ability to birth. Technology diminishes rather than enhances their control and their power to birth when the power to choose and control technology remains in the hands of others.

Risk Discourse

The concept of risk pervades much of the talk in contemporary maternity care and midwifery writings. It is very closely allied to the concept of normality and abnormality discussed above and it will be revisited in later sections of the thesis, particularly in the midwifery dilemmas regarding guidelines for professional practice and clinical indemnity insurance. As Beck who coined the term a ‘risk society’ (1992) put it:

‘Risk and *responsibility* are intrinsically connected, as are risk and *trust*, risk and *security* (insurance and safety).’ (Beck 1999:6 World Risk Society)

I will address risk and trust and safety in the section on autonomy (chapter six) where the trusting relationship that Edwards (2001, 2005) and Smythe (1998) argue is the basis for maternal safety in childbirth, is discussed as an integral part of birthing autonomy. I will also address risk and insurance in the separate section on insurance (chapter nine). Risk and responsibility are addressed in the section on the dilemmas associated with the acceptance or rejection of professional guidelines (chapter eight) and again in the section on transfers to hospital. I will also however consider risk very briefly here as it is responsibility for risk that seems to pervade dealings between obstetricians and midwives undertaking to attend births at home. It seems also that it is differences in allocation or acceptance of this responsibility that differentiates their thinking.

As Mary Douglas (1986) put it,

‘The well advertised risk generally turns out to be connected with legitimating moral principles.’ (Douglas 1986:60)

Later in her book, ‘Risk and Blame’ (1992), she describes three typologies for attribution of blame. These are associated with three social structuring typologies she developed in much earlier writings on Purity and Taboo (1966). I mention this only because it strikes me that these three typologies fit very neatly with the social structuring relevant to obstetricians, mothers and midwives in contemporary Ireland. In Douglas’ hierarchical typology she identifies that blame is moved down towards those at the bottom of the hierarchy. Obstetricians can be understood to be clearly at the top of the maternity services hierarchy. Midwives are certainly lower down and, uncharitably, women even further down. Victim-blaming has been reported in many health service settings (for example Balshem, (1993) in regard to cancer risks). In maternity settings, certainly in home birth, this pattern is very visible. Marie O’Connor (1995) amongst others reports women being told that the responsibility but more explicitly the ensuing blame should ‘the worst happen’, lay with them when they chose home birth. Women have told me similar stories during this ethnography. Midwives too, as will be demonstrated later in

midwifery dilemmas (chapter eight), report that they often feel, or are explicitly, blamed for circumstances around transfer to hospital of planned home birth.

In Douglas' market typology, the consumer is king and blame tends to be passed up either towards those providing the service or to the structures responsible for governance. This is a contradictory direction to that in the hierarchical typology, but it fits well with contemporary health structures where governing bodies of the professions, or the hospitals, or individual practitioners through their insurance, are vulnerable to accusations of blame and being held responsible for compensation.

Douglas' final group typology is the sectarian or communist where the small (often nascent) ideologically cohered group blames an out-group for loss or damage. I can see that independent midwives and home birth activists sharing an ideology at odds with the dominant grouping can blame that dominant group for all the ills of the maternity services. This mix of blaming strategies, if they can fairly be used as a model for the groups within the maternity care setting, demonstrates that conceptions of risk and blame are very complex. There is potential for different actors (or groups of actors) having very different conceptions, not only of risk, but of responsibility. They are likely too to have different strategies for avoiding or (potentially) accepting risk and blame. These strategies or the 'legitimizing moral principles' are likely to be incongruent and possibly inexplicable or even intolerable to another grouping.

Murphy Lawless (1998), Chalmers (1989), Symon (2006) and others have written about the poor predictive validity of most risk assessment tools. Yet risk avoidance, risk aversion perhaps even what could be characterised as irrational 'risk phobia', pervades contemporary western maternity practices.

'Risk society 'harbours a tendency to a *legitimate totalitarianism of hazard prevention*' (Beck 1992:80)

This totalitarianism has been recognised by sociological writers on birth like Jo Murphy-Lawless and Lorna Weir.

'obstetrics seeks to rationalise its practices on the basis that it can control exposure to death. It cannot,' (Murphy-Lawless 1998:15)

‘Death and birth, for women and for babies, can and does occur. Neither obstetrics, ... nor women ... , can deny this reality.’ (Murphy-Lawless 1998:243)
and

‘As governance in maternal and child health services came to be driven by the goal of reducing perinatal mortality and morbidity rates, it incited the impossible popular hope of driving death from pregnancy and the birth process.’ (Weir 2006:186)

The consequences of accepting obstetric definitions of risk and its attempts to control it are stark.

‘obstetric science which has sought to minimise the potential of the female body in labour and birth while maximising its control of that body.’ (Murphy-Lawless 1998:15)
and

‘Those who fail to be incited by the promise of security are considered for disciplinary correction.’ (Weir 2006:188)

Walsh, El Nemer and Downe (2004) argue that the ideology of the risk discourse needs to be reframed. They suggest that Nolan’s (2002) reframing of risks and hazards as benefits and efficacy leading to satisfaction with the birth experience, is more appropriate to a social model of childbirth. This differentiation between a risk focus and a health focused perspective parallels the difference between the focus on abnormal and normal discussed above. It permeates the difference in attitude to technology and judgements of its appropriateness. Weir, in her interviews with midwives captures this difference, and something of the tension that this can bring to those with a health focus working in a system that is risk focused.

‘Health and the normal in clinical practice were not interpreted through risk judgements. Risk-based prenatal care was judged unsuitable for care of the physiologic pregnancy because it resulted in unnecessary interventions with adverse effects.’ (Weir 2006:106)
and

‘The midwifery commitment to treat pregnancy as a state of health is analytically distinct from, and in tension with, the interpretation of pregnancy as a state of risk.’ (Weir 2006:107)

Hospitalisation, institutional hierarchies and business

The relative status of the professions and their strategies for claiming and maintaining status (professionalisation) are discussed later in the thesis (chapter seven). Maternity

services in Ireland are predominantly delivered in increasingly large and centralised hospitals where structural arrangements privilege and promote the medical model. I wish, briefly, to indicate how these structural arrangements overlay the concepts already considered and make alternative discourses and practices difficult. Taken together, a focus on abnormality, technological intervention and risk, are sufficient to explain why women might be less than happy with a medical model of care. Each undermines her birthing autonomy. It is, I propose, the gathering of these three perspectives on birth in the one place that encourages some to choose to birth elsewhere. Maternity hospitals may well have individuals within them who have a different vision for birth, but the structural and hierarchical arrangements of institutional care make an already dominant perspective virtually hegemonic. Relations of power within hospitals can be very trying for those with less power; it can be hard to express a dissenting voice. Independent midwives choose to practice elsewhere and yet must still negotiate with the institutions and those within them.

Hospitalisation is proposed by Foucault (1973) in 'The birth of the clinic', as a means for gathering patients together in one place for the convenience of clinicians. The power of surveillance within institutional settings is discussed in his later work 'Discipline and Punish (1978). Power, knowledge, measurement, surveillance all intersect in his work. Foucault's work is used as a framework to structure a critique of the operations of power at various levels within the experience of independent midwives operating alongside mainstream Irish maternity services. Hospitalisation (and centralisation) has been the dominant trend within health service provision and serves clinician expertise (Foucault 1974) though the rhetoric is that this in turn better serves the public. This is contested by many, in Ireland particularly by Maev Ann Wren (2003) and Patricia Kennedy (1999, 2002, 2004). Public dissatisfaction with closure of local hospital services and a government commitment to primary care hardly seem able to stem the tide of closures of maternity units (Kennedy 2002). Perkins (2004) argues that a business ethos within health services seems to accentuate the deficiencies of institutional indifference to individual concerns and that seems evident in the Irish context.

Obstetricians hold the top positions of authority in the Irish maternity hospitals. Hospital and professional hierarchies give rise to a tendency for the buck to stop at, or to be passed to, the obstetrician in charge. This has become deeply engrained in the hospitalised and centralised maternity services in Ireland. The belief in the ultimate responsibility of the obstetrician is signalled by the printing of her or his name at the top of the ‘patient’s’ hospital notes. To the majority of hospital employees, of whatever profession, this arrangement is understood and accepted. In facilities where midwifery led care is in its infancy, the practice of consultant headed notes is hotly contested as symbolic of underlying and deeply ingrained dominance of midwifery by obstetrics. The symbolism and dominance is perhaps overplayed where the real issue is, I suspect, the final professional responsibility for care. The midwife may be ‘an expert’ but in the hospital setting, the obstetrician is ‘the expert’. In consultant-led units, the majority of care is midwife delivered but not midwife-led and it is questionable that it is women-centred. If all care delivered by a midwife is on her own responsibility, and for which she is fully accountable, how does the belief in the ultimate responsibility of a named consultant still hold such currency? There must be, and is I believe, a disconnection between midwifery rhetoric in this regard and the practical operational relationships in hospital maternity services, perhaps especially so in the Irish context. This ethnography is not of hospital midwifery practice and so cannot directly address this issue. What can be drawn from this ethnography is twofold; that independent midwives have found it impossible or at the very least highly problematic to practice with full autonomy in a hospital setting, and secondly, that in their subsequent domiciliary practice they have found dealings with the maternity services and obstetricians generally to continue to be pervaded by such a notion of professional dominance.

Cheyney (2008) cites Singer’s (1995) term ‘system challenging praxis’ to describe home birth as a practice which is more radical than ‘systems changing practices’ because home birth represents a rejection of the dominant system of birth. Home birthers and their midwives do not accept the dominant discourses of techno-birthing (Davis-Floyd and Mather 2002). Home birth and independent midwifery are lived, practiced, challenges to the system. This ethnography is something of an exploration of the hows and whys of that

praxis. This study begins to draw together the rhetoric, the discourse and the practical implementation of independent midwifery as a viable alternative to institutionalised techno-birthing. The discourses antagonistic to home birth addressed in this section are expressed in wider structural resistance to home birth and to independent midwifery practice. The discourses of the medical, technobirthing fraternity are so pervasive that they are seen not only amongst obstetricians but amongst all professional groups and wider societal attitudes. Midwives too have acceded in large part to what Murphy-Lawless (1998:16) has called ‘this generalised fear, this nameless globalised anxiety about childbirth’.

Independent midwives acknowledge and must also address the reality of this fear and temper their work accordingly.

Section Two Muted discourses: suppression of alternative knowledges as putatively unprofessional

During the ethnography I noticed a lack of discussion of topics of spirituality and intuition in the talk of independent midwives. This was despite a considerable body of writings that report these in the experience of women and midwives in all midwifery settings (Colgan 1992,⁵⁹ Williams 1997, Parrat and Fahy 2008,) but particularly in home birth settings (Roncalli 1997, Daviss 1997, Davis-Floyd and Davis 1997, Davis-Floyd and Arvidson 1997, Klassen 2001, Cheyney 2008). I was concerned that my presence as a male researcher with a background in education (as discussed in chapter two, section seven) might be inhibiting talk of these things. I therefore mentioned this concern and asked explicitly about spirituality and intuition and birth and some of the midwives did explore these issues with me. Nevertheless, I took reticence on these topics to be another expression of the midwives’ desire to present themselves as professional and acceptable to outside observers (rather than an artefact of researcher reactivity).

Antagonism to home birth and midwifery in Ireland has been outlined in the introductory chapter. The historical use of professionalizing discourses about obstetrics and its

⁵⁹ Colgan (1992) uses the phrase ‘Midwives are the guardians of childbirth who bring to labour a special intuition that enables women to give birth without intervention’ during her two interviews with community midwives. She asks the midwives to what extent they agree with this statement, but she makes no indication from where this phrase or idea has been taken.

knowledge power, have been outlined earlier in this chapter. The mastery of science and purging of the putatively irrational activities of the traditional midwife has been described as a major professional closure strategy of obstetrics (Rich 1977, Towler and Bramall 1986, Rothman 1991, Mitford 1992, Witz 1992, Martin 2001). These together may be the cause for midwifery reticence regarding knowledges based outside scientific and professional orthodoxy. Spirituality and intuition are aspects of human experience that do not easily fall within the scientific paradigm which dominates claims to professionalism (Wilkins 1993).

Parrat and Fahy (2008) however make a cogent argument for consideration of the non-rational (as opposed to the irrational) in midwifery:

‘While we may make rational assessments and shape our actions according to rational mores and social norms, as embodied selves we also have sensations and experiences that are *nonrational*. These *nonrational* experiences influence our ways of being whether we acknowledge them or not.’ (Parrat and Fahy 2008:41)

‘These experientially grounded, *nonrational* aspects of life have been described variously as mysterious, sacred, spiritual and intuitive.’ (Parrat and Fahy 2008:38)

Cartesian dualism, derived from the work of Descartes, ‘A Discourse on Method: Meditations and Principles’, first published in 1637, analyses abstract concepts in opposing pairs. This has been critiqued by feminist writers as unhelpful (Lupton 2006, Wilkins 2000), not least because it denies careful consideration of intermediate states. It is also unhelpful because the opposites are usually differentially valued and furthermore often associated with gendered notions of which attribute is more male or female (Jordanova 1989, Jaggar 1996, Martin 2001). Take for example the use of the words rational and non-rational in Parrat and Fahy’s quote above. This pairing is very different from but all too similar to, and easily confused with, the pairing of rational with irrational. In turn that pairing is associated with a professional and un-professional pairing. There is no reason that non-rationalism should be paired with unprofessional except that the rational has been so strongly associated with professional as part of a device for legitimising professionalism.

Language associations, gendering and the ascription of value norms (normativisation) are very powerful rhetorical devices. The link between female and intuition is significant and is tied up with the very many associations between the feminine and devalued qualities (Jordanova 1989, Jaggar 1996, Martin 2001).

Such is the wholesale co-option of science by professions and in the characterisation of professionalism (Wilkins 1993, Hughes 2006), that knowledges that do not easily fit the scientific paradigm are rejected as unprofessional. Independent midwives aware of the norms (and normative pressures) of professional discourse demonstrate a wariness of frank allegiance to subjected knowledges.

Midwives if they personally espouse an intuitive or spiritual aspect to their practice subdue that allegiance in their presentation of the professional persona. Yet independent midwives do incorporate their experiences of intuition and spirituality into their practice. I will consider each in turn.

Intuition

Davis-Floyd and Davis (1997a 1997c) discuss the concept of intuition and its transgressive nature within the biomedical system. Defining the exact nature of intuition however is very difficult. Davis-Floyd and Davis use the word connection as the foundational requirement. Connection is, I think, synonymous with the qualities described in this thesis in chapters four and six on relationship as the basis for autonomy. I understand Davis-Floyd and Davis' 'connection' to be the same as the midwife's 'being with', being receptive, being available to, present for, or responsive (response-able) to, the mother.

Lucia Roncalli (1997) a midwife, describes the majority of instances of intuition in her experience as being seamless attunement to the mother and to the birthing process.

It strikes me then that intuition is not so much a metaphysical revelation (about which a scientist might have reservations) as a heightened sensitivity to the signals about progress and wellbeing that are derived from a combination of close trusting relationship and breadth of birthing experience. Davis-Floyd and Davis (1997:105) describe insight as the

result of validation of intuition, so again there is an element of confirmation not ‘blind faith’ in the application of intuition.⁶⁰

Krogstad, Hofoss and Hjortdhal (2002:37) call intuition the ‘capacity to assimilate different types of knowledge’. They recommend using reflection on these knowledges, these ‘grey areas’, as a means for increasing knowledge and trust. They describe a need for improvisation in the use of knowledge resources rather than delimitation.

Intuition has also been described as an uncommon sense (Daviss 1997). Roncalli’s idea of intuitive attunement, she also calls an interactive intelligence or a ‘divining empathy’(1997:183). Again the word divining has a mysterious or mystical connotation. This special sensitivity to a person and a context is difficult to verbalise, not least because it has been dismissed (and worse) by the dominant discourse. Intuition has been ridiculed as irrational and dangerous and as an ‘old (mid)wives’ tale’. That intuition is difficult to articulate means it remains somewhat hidden, it is ‘occult’. As a heightened sensitivity it is more than natural, thus it is ‘super’ natural. It is easy from these examples to see how the non rational aspects of midwifery knowledge have layers (and years) of negative connotations attached to them. Links between divination, the occult, the supernatural all evoke a view of (female) intuition and midwifery as magic and witchery. These are derided associations from many centuries ago (Ehrenreich and English 1973) but which prove difficult to shake. The questions are: should, and why should we midwives shake off these connotations? Could it be that by denying the non-rational in the hope of appearing more professional, we risk losing crucial aspects of our sensibility, something valuable in our ‘being with’ women ?

Interventions such as getting the woman to change position in labour, or to go for a walk ‘to change the energy’ are without clear evidence to support them. Yes movement and an upright position are rationally associated with promotion of progress, but the exact timing

⁶⁰Evelyn Fox Keller (1983) writes of the work of the geneticist Barbara McClintock and identifies McClintock’s ‘feeling for the organism’ and ‘becoming part of the system’ as central to her work, which by acknowledging the intuitive, the feeling, is in philosophical opposition to the dominant discourse of scientific rationality and putatively dispassionate objectivity.

or choice of intervention is entirely up to the mother's or midwife's reading (or sense) of the situation. The midwife may well offer a rationale but language such as 'energy' is difficult to defend within a strictly scientific rationality.

Anne Fry, editor of the book 'Holistic Midwifery' (2004) advises:

'Choose the words you use to discuss this concept carefully, some people will be offended by the word "energy" but will grasp the concept when explained in other ways.' (Frye 2004:414)

Much of the midwife's work is about reading the signals from the woman's body, and about knowing her personality traits, much is not about measurable physiological attributes such as blood pressure. Attributes like the woman's energy, resilience, determination or despair inform the midwife about what are possible courses of action. The midwife is supporting and promoting the woman's birthing autonomy through relationship. It is in that relationship, that holistic acknowledgement of the very many facets of human existence: embodied knowledge, emotion, hopes, dreams, fears and non rational experience, that the path to an engaged and empowering birth is negotiated. Maintaining dynamism in the birthing environment, be it physical movement or emotional and psychological vitality, is nuanced. It requires social and emotional sensitivity and skill to enact.

Cheyney (2008) explicitly links intuition and embodied knowledge. The embodied, felt, physically experienced aspects of knowledge are necessarily highly subjective and yet they are familiar, recognisable, phenomena. There is a link between physical sensations and emotions (Hunter 2001, 2004, Shilling 2005). Science's inability to successfully incorporate subjective knowledges including the nature (and use) of emotions and embodied knowledge into its more objective rationality, may well be the basis for professions rejection of them (and intuition) as data source and knowledge base appropriate to professionalism (Jaggar 1996). Outright rejection of the utility of subjective knowledges in interpersonal relations and in supporting the birth process is not useful (Hunter et al. 2008). Those committed to a holistic attitude towards birth must incorporate these knowledges and attempt to understand concepts such as intuition.

Nonetheless several midwives spoke of their own intuition or instincts (p2L1 FN 21Feb08, p9L3 Int 13Feb07). Some recommended that I attune myself to these and attend to them, especially if my intuition tended towards increased caution (p34L45 FN 20Nov 06).

One midwife tells the story of woman whom she was attending who was only 7 or 8 days over her dates (EDD). The woman was not in labour and not at a stage of pregnancy when the midwife would be concerned but she felt something was not quite right; something intuitive at palpation or about the woman's history gave the midwife cause to be concerned. The midwife acknowledges there was 'nothing documentable or clear' but nonetheless, based upon that intuition, the midwife transferred her to hospital care. It turned out the baby had a significant cardiac blood vessel transposition which was incompatible with life. The midwife was very relieved that she had decided to transfer for investigation. She acknowledges however that often feelings and intuition miss things, or that worries turn out to be unfounded and all is well (p2L16 FN 21Feb08). The same midwife later says that feelings are not good reason for disregarding evidence (p7L29 FN 29Sept08). It seems that intuition that something is NOT well acts as an extra layer of safety. While potentially dismissible as fanciful such 'feelings' cannot be held up as dangerous. The opposite, privileging of intuition in the face of explicit signs of abnormality, would be much harder to defend (and therefore be harder to express).

'By denying other epistemological spaces, professionalism cannot comprehend midwives' or childbearing women's knowledges. Despite the many examples of women's and midwives' knowledges outside scientific evidence, it is often packaged into the supposedly mysterious and untrustworthy anathema to science – intuition.' (Edwards 2001:72)

Spirituality

An examination of the spiritual is beyond the scope of this thesis. Philosophers and theologians have discussed humans' spiritual nature for millennia and, as has been demonstrated by the argumentation of theists and atheists, the spiritual is not amenable to scientific proofs. It is beyond science, it is metaphysical. As professions base their knowledge and control of their domain on science, spirituality is beyond the jurisdiction of the strictly professional. As with intuition, acknowledgement of the spiritual arouses

suspicion in the domain of the professional. It need not be so, one could argue it should not be so, but it is so. Independent midwives talk about faith and fate and trust and soul and God and Goddess and spirituality (p8L45 FN 15Sept08, p1L45 FN 21Sept08, p5L19 and p5L42 FN 18Sept08).

They have a sense of protecting the sacred space in birth (p13L15 Int 13Feb07, p22L25 Int 09Dec08 Int, p5L13 FN 18Sept08). They are keen to distinguish between spirituality and religion (p8L2 FN 11Jul08).

I am not going to dwell upon spirituality, not because the midwives did not share with me their various perspectives on it, but because the spiritual is personal and to situate their, and my, views upon the matter would require too much time and space to place a conceptual framework upon which to hang these experiences. The significant thing for me and for my presentation of this ethnography is that there was a distinct reservation about presenting this aspect of their work and experience to me and, I understand, to any outside observers. I take this to be an expression of the difficulty that will be discussed later, but which underpins the whole of this ethnography. That difficulty is in balancing a professional persona with anything other than a scientific evidence based knowledge system. Spirituality, as with emotionality, relationality, sensitivity to non rational sources of information, can be acknowledged, shared, understood and discussed amongst midwives (FNp4L6 18Sept08) but they have to be treated with some reserve when professionalization, that is concerns with professionalism and professional status, becomes an issue.

Although, when asked to consider whether there is a spiritual dimension to their practice most midwives will acknowledge there is. One midwife says she does not raise the subject with women (p13L1 Int 13Feb07); another reports that mothers would not talk about it as spiritual, or that woman only come back later and talk about a spiritual birth experience (p3L50 FN 11Jul08).

Another says 'of course people don't talk about it but that doesn't mean that its not there' (p2L1 FN 21Feb08). There seems to be a wariness about 'implanting a version, a perspective' on spirituality that mothers might not hold themselves (p3L39 FN 18Sept08). With such reservation there is sometimes a distancing 'if'; for example when I

asked about a midwife's role in the spiritual or the sacred, one response was 'if there is such a role, my role is in allowing the birth to take place', 'in protecting that space' (p4L16 FN 18Sept08).

As with intuition, closer examination of the term spirituality and its meanings as used by midwives can remove some of the negative connotations associated with the term and allow some engagement with it rather than immediate rejection.

Pembroke and Pembroke (2008) write of the spirituality of presence in midwifery care. By using a definition of spirituality based upon immanence rather than transcendence it might be more easily accepted and made available to proponents of scientific professionalism.

'Spirituality has both an immanent and a transcendental form. An immanent spirituality refers to an orientation in which people believe that all the resources they need to find meaning and value can be found within the self.' (Pembroke and Pembroke 2008:322)

Pembroke and Pembroke go on to explore how being present (or 'being with' as I have presented it in this thesis) allows access to the spiritual as immanent. Consideration of the spiritual is then available from within one's own personal knowledge system rather than as putative external (and unprovable) metaphysical phenomenon. There is no need to extrapolate an external entity (such as God) to understand spirituality in childbirth. An awareness of and sympathy for human's search for meaning can come from a holistic consideration of the person. The woman's (and the midwife's) belief system do not have to be understandable, explicable, or subjected to proof; it simply is part of their knowledge and interpretive system. Failure to acknowledge the spiritual aspect can be constructed then as unprofessional, as a lack in the skills and competencies of the professional.

Summary

This chapter has explored some of the discourses that pervade contemporary maternity services and underpin its risk-phobic, controlling and interventionist philosophy. The discourse on normality and abnormality is particularly interesting as it straddles the

interface between the competing ideologies and professionalizing projects of midwifery and obstetrics which will be further explored in chapter seven.

The concepts of intuition and spirituality have been examined very briefly. They are examples of knowledges that would seem to be muted within the professionalizing project of midwifery. They, like a focus on relationship and an acceptance of alternative medicines, are somehow not identified as consistent with professionalism. Professionalism is defined by a narrow conception of knowledge as predicated upon scientific method. The power of science to support progress in industrial and modern society has given its methods significant cachet as part of any professionalizing claim. Other knowledge sources are consequentially devalued, indeed their application brings suspicion of non or unprofessionalism. The dominant, indeed authoritative discourse (after Jordan 1992) in contemporary maternity services is the scientific; any threat to its dominance is construed as indicative of unprofessionalism.

Midwifery commitment to holism, relationship and women's birthing autonomy needs must embrace alternative knowledge systems. Thus professionalism and midwifery philosophy are to an extent at odds. This is expressed in a certain muting of 'other' knowledges.

Chapter Six

On autonomy

In this chapter I want to do two things. The first is to discuss the concept of autonomy and to argue that an individualistic autonomy is problematic for reproduction and birth; a relational autonomy is therefore more suitable for understanding autonomy in childbirth. The second purpose of the chapter is to demonstrate that the relationship between the mother and the midwife is central to promoting birthing autonomy. The notion of 'being with woman' is relational, that is, it is founded upon relationship. I wish to demonstrate that the independent midwives in this study support the principle of birthing autonomy in both their rhetoric and in their actions and relationship-building with women.

The whole chapter (and the next on professionalism) helps me to set out to my contention that midwives struggle in their day to day practice to maintain women's birthing autonomy. Midwives strive to promote birthing autonomy in a context of also striving to be professional. These twin concerns of 'being with' and 'being professional' raise many dilemmas for the midwives. Some of those dilemmas will be discussed once the concepts of autonomy and professionalism have been outlined.

Autonomy individualistic or relational ?

Autonomy, the freedom to make uncoerced decisions and choices about one's own life and actions, is a concept of human dignity and personhood that underpins ethical behaviour and the ethical treatment of others (Beauchamp and Childress 2001). What makes a decision autonomous is not the outcome, the decision or choice itself, but rather the process, the conditions under which it is made. Freedom to choose is dependent upon two major factors, the first being information, as complete and accurate as possible including reasonable extrapolation as to the consequences of the decision or action. It is this aspect that is upheld in the principle of informed consent. (O'Boyle 2006) The other aspect of freedom derives from a conception of a person as free from any contextual dependency upon, or responsibility for or to, other persons. This extreme individualism and denial of human relationality has been contested by Sherwin (1998) and Mackenzie and Stoljar (2000). They amply demonstrate that individualism is deeply gendered, epitomised by the 'self-made man'. It denies social structures that view and construct the

feminine as dependent upon and nurturing of others. Humans are born and raised in relationship to others, and no person is without relationships and responsibilities to others. Mackenzie and Stoljar thus argue that consideration of autonomy without context is operationally untenable. They argue instead for a more relational autonomy which does not depend on such extreme individualism.

‘If the agent is socially constituted, as many feminists believe, capacities of the agent like autonomy are also constitutively social and relational.’ (Mackenzie and Stoljar 2000:23)

Thus,

‘conceptualizing agents as emotional, embodied, desiring, creative, and feeling, as well as rational, creatures highlights the importance to autonomy of features of agents that have received little discussion in the literature, such as memory, imagination, and emotional dispositions and attitudes.’ (Mackenzie and Stoljar 2000:21)

This concept of autonomy as relational chimes very strongly with what I have seen in independent midwives’ relationships with women, and heard in midwives’ retelling of their experiences in independent midwifery practice.

Birthing autonomy is based upon being in relationship (safety)

Women describe relationship as being the essential element in their empowerment (O’Connor 1995, Smythe 1998, Edwards 2001, 2005 and others). Nadine Edwards (2001, 2005) describes ‘birthing autonomy’ as the quality of the woman’s self-determination and engagement in the birthing process which is requisite for successful birth. Edwards points out that it is the relationship with the midwife which facilitates or mediates that autonomy. This study describes the midwife’s role in promoting birthing autonomy for women.

Success in birthing is more than simply producing a live baby from a live mother. Such an objectifying perspective comes from the dominant positivist paradigm in obstetric thinking which treats mothers and babies as objects not engaged subjects. An objectifying perspective fails to capture the subjective meaningfulness of birth and the satisfaction of having engaged fully in the process. It has no language or outcome measures to capture meaningfulness; a questionnaire item on ‘maternal satisfaction’ hardly captures the

subjective qualities of having enjoyed the power and creativity of one's own body in birth.

Not every birth, perhaps not any birth, is perfect in every way, but every birth is transformative. A sense of personal wellbeing derives from engagement in the process which is neither entirely within our control, nor entirely beyond it.

Edwards (2001, 2005) and Smythe (1998) in their work on women's experience of safety in birth clearly demonstrate that safety is enabled by the relationship women have with their midwife. It is only when a woman (any person) feels safe that they are able to surrender and to trust (Smythe 1998, Goldberg 2008); safe to surrender to the embodied process of birthing and to surrender to the ministrations of another; safe to trust in their own body's ability to birth and to trust in their midwife to maintain their safety in the uncertain trajectory of their birth process.

Being with is about being in relationship

The concept of 'being with' women is derived directly from translation of the word Midwife (Mid or mit - Old English for with, and wife or wif, – Old English for woman). 'Being with' women in childbirth is founded upon the relationship between mother and midwife. 'Being with' is more than a passive presence, it is an active engagement with the deliberate aim of promoting birthing autonomy. The importance of birth companionship is recognised in studies using both qualitative and quantitative research methodologies (Wilkins 1993 and 2000, Smythe 1998, Kirkham 2000, Edwards 2001, 2005, Hodnett et al 2005, Brown 2008, Goldberg 2008, Hatem et al 2008, Hunter et al 2008, Pembroke and Pembroke 2008, and McCourt and Stevens 2008).

Midwives in this study constantly refer to their relationship, to 'being with' and to empowering women 'to do it themselves' (see supporting data below). This language of promotion and support of women's birthing autonomy suggest birthing autonomy is not an individualistic activity but a relational one, Birthing autonomy is enhanced or hampered by the relationships and the social context in which the women (and midwives)

find themselves. This is true whether birth occurs in the hospital or in the home, whether in highly technological contexts or in undeveloped socially deprived settings.

The concepts of being present for, being engaged with, or being available to women are expressed through the mother midwife relationship and have been described by midwifery writers as essential attributes of an effective working relationship.

‘Being with’ has been alternatively described as being present (Brown 2008, Berg, Lundgren and Wahlberg 1996) as being receptive (Pembroke and Pembroke 2008, derived from Buber’s concept of responsibility or being able to respond to) or as being available (Lundgren and Berg 2007). Lundgren and Berg (2007), in a re-examination of several papers investigating the midwife woman relationship, describe six concepts which portray the needs of the mother. From these they derive six concepts, paired to the women’s needs, which portray the responses on the part of the midwife to meet those needs.⁶¹

Table 3.

Aspects of the woman’s birth experience	Midwife’s response
Surrender	Availability
Trust	Mediation of trust
Participation	Mutuality
Loneliness	Confirmation
Differences	Support uniqueness
Create meaning	Support meaningfulness

There is evident similarity between Lundgren and Berg’s concepts and the rhetoric and action of the midwives in independent practice in Ireland which I will describe below. Lundgren and Berg however do not explicitly mention autonomy as a part of the birthing experience. Each of their midwifery response concepts however can be seen to mediate the woman’s birthing autonomy by means of the relationship between mother and midwife. The concept of birthing autonomy is clearly a relational one. Particular concepts describing the woman’s experience in Lundgren and Berg’s typology would not

⁶¹ McCourt and Stevens (2008) in their study of relationship and reciprocity in caseload midwifery propose a similar juxtaposition of the mothers’ and midwives’ perspectives.

fit easily into a individualistic conception of autonomy. Surrender and trust for example are inherently relational.

As outlined above, the concept of relational autonomy recognises the context of any autonomous action and is not diminished by the concepts of surrender and trust. Rather human interaction and relationship are recognised as potentially enhancing or diminishing autonomy. Each of the midwifery concepts listed by Lundgren and Berg enhance the woman's birthing autonomy. The requirement to trust one's body and surrender to the coming forth of another life from within oneself is, to me, the most explicit expression of autonomy as relational. The new person is enabled into existence by the generosity, the openness of the one to the other, the mother to the child. The woman is enabled to birth, to be fully engaged in the birthing by the support of her birthing companions. Birthing autonomy is a relational autonomy. 'Being with' as an autonomy enhancing practice, involves all of the midwifery concepts identified by Lundgren and Berg. Availability is perhaps the single greatest in Lundgren and Berg's because it makes all the others possible. Simply by 'being with', 'being available' to woman, the midwife enables birthing autonomy. The woman- midwife relationship is therefore the foundation for autonomous birth.

Independent midwives' rhetoric and action support birthing autonomy

The principle of birthing autonomy appears not only in midwifery talk but is also evidenced in their practice. The principles of autonomy described as the process and ability to make self determined decisions have been discussed above and expanded to incorporate relational aspects. Nadine Edwards (2005) describes how birthing autonomy is enhanced or reduced by the quality of the relationship between the midwife and the woman. The midwife is the mediating influence in otherwise disempowering circumstances. Edwards however, also describes women's experience where the relationship with the midwife is undermining rather than enhancing of birthing autonomy. In the following section, I have categorised the explanations midwives give of 'being with' women under the heading 'birthing autonomy rhetoric' listing four aspects or expressed beliefs that underpin independent midwives' concept of birthing autonomy. I

have also observed various expressions of that rhetoric in their practice, summarised under the heading ‘Being with’ in Action’ (see Table 4 below).

Table 4.

Birthing Autonomy Rhetoric
Belief in the right to (rightness of, self evident good of) self determination
Belief in a woman’s body to birth
Belief in woman’s resources to birth (personal resources, strength of will, physical endurance, psychological and emotional coping strategies, woman’s or midwife’s belief in external metaphysical, spiritual supports)
Belief in social support / relationship (midwife) to enhance autonomy and facilitate birthing
‘Being with’ in Action
Presence, Availability
Time, Silence, Listening, Asking
Respect, Responding & Anticipating
Information, Choices
Engagement of woman in decision making
Woman’s ownership / Responsibility for decisions
Countering dependence or abdication of responsibility
Promotion of social and personal resources, practically
Promotion of woman’s self belief / confidence

Birthing Autonomy Rhetoric

Independent midwives believe in the principle of women’s self determination in childbirth. Midwives believe women can birth on their own, but that that innate ability is fostered in relationship with others, particularly with the support of a midwife. The following excerpts are taken from my field notes:

‘They’re making health decisions here about their pregnancy, their baby, their body. (p6L32 FN 21Oct07)

‘In terms of their view of birth the cup is definitely, definitely half full. That’s what defines the alternative system, that’s not there in the hospital system where they’re looking for what’s wrong all the time. All midwife led systems look to promoting

wellness. Women in hospital can come to believe that there is something wrong with them, not with the independent midwife usually' (p5L42 FN 21Oct07).

Midwives express a belief in woman's resources to birth. These include personal resources (p2L32 FN 07Jul07), strength of will, physical endurance, psychological and emotional coping strategies. They may also include the woman's belief in external metaphysical or spiritual supports. One midwife feels the central tenet of midwifery 'is to help them find their own way' (p2L25 FN 21Feb08). Several mention not 'labour watching', that is leaving the woman to labour without disturbance (p6L9 FN 29Sept08). The following statement is also typical 'I'm not person who delivers the baby – it's the mother' she/ he / we must work together as a team (p8L47 FN 18Sept08).

Taken together these examples demonstrate that midwives present themselves as promoters of birthing autonomy.

Independent midwives express a belief in social support, and believe that their relationship with the woman will enhance autonomy and facilitate birthing. One described an antenatal visit as being mostly social and that 'that social element is just being available for women, for them to ask questions' (p12L29 FN 20Nov06).

One midwife extended that availability and presence to a role in advocacy, but feels, 'In Ireland they don't understand the midwife's role as advocate' (p2L9 FN 21Oct07). She promotes 'advocacy for a certain way of relating to human beings. I do it in relation to birthing but I could also do dying [terminal care]' (p2L43 FN 21Oct07). She sees, 'In birth there's an incredible vulnerability' (p4L18 FN 21Oct07), and says:

'If women had more support, time, access to other women, more empowerment in the process of birth, as opposed to the focus on labour and the baby coming out focus. If they had information on the process of birth, time for discussion and advice, there would be less intervention. Birth would be personal for women if they were given those circumstances, at the moment choices are taken away from them (p6L34 FN 21Oct07).

Thus further to the belief in the woman's own ability to birth, the midwives see their role as supporting that ability and furthermore that it is the quality of their relationship that enables that supporting or autonomy enhancing function.

'Being with' in Action

Promotion of birthing autonomy is not confined to rhetoric however, it is put into practice in every aspect of their relationship with women.

The expression of birth enhancing relationship is seen in this ethnography in a multitude of actions.

Each subheading under 'Being with' in Action' in table 4 above, is supported, in the following paragraphs, from ethnographic participant observation.

Presence or availability is demonstrated in myriad small ways but particularly in giving time or social space in silence, in **listening, asking and waiting** for response. One midwife describes giving a couple such **space** in labour 'to get their own rhythm to coping' (p22L33 FN 20Nov06). **Listening and respect** is demonstrated in the appropriateness of responses but also in correctly **anticipating** the woman's or couples **informational** or support needs. The midwives build up and maintain the woman's birthing autonomy by actively encouraging engagement of the woman in **decision making**, in taking **ownership** of decisions and countering any tendency to abdicate responsibility. For example if a mother, given a choice, says 'whatever you think' a typical response from the midwife is to say 'I can't tell you, you decide' and to present again the options and supporting rationale (p4L25 FN 28Jun06).

(Further specific examples drawn from observations and recorded in field notes and my research diary are listed in appendix one.)

Counter-instances

There are instances however where independent midwives would seem to be behaving in autonomy diminishing rather than enhancing ways. I have characterised some of these as being genuine counter examples, most however seem to be neutral with respect to the woman's birthing autonomy rather than actively undermining. Perhaps these below are less counter instances of diminishing birthing autonomy, than instances of the midwives'

dilemma in having to balance birthing autonomy with other concerns such as professional autonomy, professional authority and presumed responsibility as the professional.

The costs of being available

In their talk, midwives sometimes give the impression of being less than sympathetic to women describing them as intense, demanding or ‘pulling out of you’. This I have interpreted as simple recognition of, and struggle with, the emotionally demanding nature of being available for another person. One midwife said ‘you have to be tough, to protect yourself from the energy you’re getting from the women’ (p9L6 FN 20Nov06) and another, ‘Transfers sometimes have been as much to do with me as it has with them. I have run out of energy.’ (p8L3 FN 11Jul08).

In order to moderate that emotional demand some midwives try to limit their accessibility by asking that their home telephone not be used after 7pm – ‘except in emergency’, or by not giving personal mobile telephone numbers (p7L18 and p17L27 20Nov06).

Persistence and ‘really wanting’ home birth

Midwives will often say that women who ‘really’ want a home birth are persistent in their attempts to secure a midwife to support them. That is often the case, but this manner of thinking undermines their own rhetoric of enhancing autonomy by being available. It dismisses those who are not persistent, those who respect the midwives first ‘No’ as ‘No. Furthermore it feeds into a post hoc dismissal of women who later request transfer into hospital (for analgesia or having reached their emotional or physical limit) as not ‘really’ being committed to a home birth in the first place. This doubt in the mind of some midwives about the ability or commitment of some mothers to the demands of intervention free birth at home, is inconsistent with their expressed belief in a woman’s ability to birth. It is however also a product of their experience that some women have not been prepared for the quite extreme call upon their own resources during labour. Such women have then (rightly) resorted to hospital interventions, thus leaving the midwife redundant after considerable commitment. An awareness of the emotional costs of human engagement as birth attendant seems, again, to underpin this example of a midwife’s self-protection mechanism.

Declining to provide home birth support

As has been discussed under the day to day logistics of being a home birth midwife, the midwife may often simply be unavailable when a woman expects to have her baby. In several instances the decision to decline to be a woman's midwife has been based upon factors such as the presence of a 'controlling' husband (p4L25 FN 17Oct06) or an overbearing sister (p1L43 FN 27Jul07), and in these contexts the birthing autonomy of the individual seemed, to the midwife, to be already so compromised as to be too difficult for the midwife to redress. Other instances where some midwives decline to offer home birth support are where there is substance misuse or where the woman smokes (p7L32 FN 29Sept08). Another declines to take on women who say they are not going to breast feed (p5L13 FN 24Sept07). The midwives argue however that these contextual features demonstrate a lack of women's commitment to themselves or their baby that is inconsistent with optimal birthing.

A more acute example which captures the dilemma of balancing women's and midwives' autonomy is seen where a midwife who says: 'I wouldn't [do home birth] if they were saying they wouldn't go [to hospital]' (p8L40 FN 21Sept08). The a priori refusal by the mother to go to hospital undermines the midwife's own autonomy to make professional decisions that home birth is no longer consistent with good outcomes for the mother or baby. This unilateral closure of options by the mother has two consequences. Firstly it leaves the midwife in a situation where she is unable to act (or advise) as she would wish. Secondly it is saying that the woman does not trust or is not interested in the judgement of the midwife.

The midwife is under no legal or professional obligation to be available to every woman who seeks a home birth. When she declines a woman, the individual midwife however finds her own personal or professional autonomy at odds with the woman's. The midwife is in personal contact with a mother requesting a home birth. When the midwife cannot, or chooses not to, facilitate her, the midwife must recognise that her autonomous choice impinges upon the mother's choices. Choice limitation is undermining of birthing autonomy, and failing to provide birth choice is exactly the charge against the State and the HSE. The State and HSE however do not have to face the personal effect of limiting

that choice. The State, I (idealistically) believe, is properly the servant of the people and yet is failing so to serve. Paradoxically then, it is those who ordinarily do facilitate birth choice who must face the prospect of personally admitting they will not (for whatever reason) facilitate that choice for a given woman. The individual midwife bears the personal burden (in both accepting and declining to serve) of a State system that does not face its responsibility to facilitate birth choice. (The consequence of unattended birth is discussed later in chapter eight.)

These examples demonstrate the complexity of negotiating both the woman's birthing autonomy and the midwife's own autonomous personal and professional actions. There is no easy resolution in such instances of competing autonomy. Accepting that all autonomy is relational however, disinclines one to see individual autonomies as necessarily competing.

Each of these three instances of apparent contradiction to the principle of birthing autonomy clearly do not actively take autonomy away; they do not remove freedoms otherwise available. They might at worst be considered a refusal to enhance a woman's birthing autonomy at a cost to their own autonomy. Responding positively to persistence might be considered to be a test or measure of the commitment requisite to fully engage in autonomous birth. These examples do not, I feel, negate the general and more usual promotion of birthing autonomy in both the midwives rhetoric and actions. Rather they demonstrate the midwives' awareness and general acceptance of the emotional cost of the midwife mother relationship. That cost is often unacknowledged in the midwives' enthusiasm in extolling the rewards of their work. What follows is a consideration of instances where birthing autonomy seems to be more clearly undermined in some mother midwife relationships.

Appropriate information

Many midwives avoid the invasiveness of vaginal examination in home birth wherever possible. They rely instead upon other non-invasive signs of onset and progress in labour. This is consistent with an intervention free birth and is usually unproblematic. The lack of a documented vaginal assessment of progress can however be problematic

when transferring to hospital. The dilemmas of transfer are discussed separately in chapter eight.

Of those who perform vaginal examination however some decline to tell a woman the specific details of the signs of progress such as the dilatation of her cervix. This is not, they argue, because the woman does not deserve the right to full information, but rather that such specifics are of little utility to the mother (p33L43 and p37L22 FN 20Nov06). Such detailed feedback may set up an expectation, derived from institutionalised norms (progress measured on a partograph of one centimetre dilation per hour), that are inappropriate because of the individual and dynamic nature of birth. The inappropriateness of this expectation is true in any setting, but particularly at home where the focus is on wellbeing rather than rigid rule bound time limits. This having but withholding information could be construed as autonomy diminishing as full information aids choice. It seems however that the midwives, in the context of their relationship of trust with the women hold this kind of information in quarantine. The midwives know the information but reserve it perhaps for the appropriate context. The professional quantitative estimation of progress is linked to the professional paradigm, the context and practices of active management of birth in hospital and may be needed as some sort of justification for the midwife's ongoing management but it is irrelevant to the personal paradigm and the embodied experience of birthing. The whole notion of differing knowledges between the mother and midwife however requires the consideration of the meaning of that difference. In a relational autonomy conception, it does not mean the midwife and mother are in any way at odds but rather promotes their combined efforts and knowledges towards birthing autonomy. The birth is not the midwife's, the mother's, or the baby's alone but theirs, the family's, the social circle's birth.

Uncertainty and knowing the mother's mind (safety and trust)

There can be considerable temptation for the woman to abdicate autonomy or responsibility and to put pressure on the midwife to 'take over'. This is a delicate situation for the midwife who wants to promote birthing autonomy but who also recognises the need for the woman to 'let go', to surrender (Anderson 2000, Lundgren and Berg 2007) particularly during labour. In active labour, more so than at other times,

the midwife may give instructions rather than make suggestions that the woman might or might not take. As one midwife put it: ‘Sometimes you have to call a spade a spade be ‘bossy’ (p6L32 FN 21Oct07). Another was very clear when she directed a mother to get out of the water where there was delay in delivery of the baby’s shoulders during a water birth (p3L21 FN 24Apr07). In such instances then the midwife appears not to be enhancing birthing autonomy. However the relationship that the mother and midwife have built up is a trusting one (as articulated by Lundgren and Berg 2007 above, but also described in Edwards 2001, 2005 and in Smythe 1998). The knowledge they have of each other is such that midwife correctly understands the mother’s hopes and intentions for the planned birth. The mother, assured of their shared vision for what birth can be, trusts the midwife. The shared vision, built upon and into the relationship, allows the midwife to act appropriately should specific unpredicted indications arise during the birth. Both mother and midwife expect that they will not violate the trust they share. It would appear their relationship allows that the midwife may make judgements about necessary intervention that she would otherwise have spent time discussing with the mother. Birthing autonomy, again, is relational, expressly supported by relationship and not undermined, but rather enhanced, by relational concepts like the mother’s trust and the midwife’s acceptance of responsibility.

Professional authority

There are times when a particular action may seem feasible to a mother but the midwife’s own judgement suggests otherwise. One mother for example, who was keen to go into labour, requested a membrane sweep⁶² during antenatal vaginal examination, but the midwife during the examination did not feel it was appropriate (p4L10 FN 14Jun06). Another midwife declines to perform artificial rupture of membranes in labour even though she says women may ask for it in the belief that it may speed labour. She feels that such intervention can be the beginning of a cascade of other unintended interventions (p5L16 FN 28Jun06).

⁶² Digital stimulation of the cervix or digital separation of the chorio-amnionic sac from the internal os of the cervix is theorised to release prostaglandins which might promote the onset of labour Boulvain, Stan and Irion (2004).

These midwives are asking the woman to accept their decision, their midwifery knowledge and experience, as authoritative.

In the first case, even while the midwife was making that clinical judgement (that labour might still be some days or more away,⁶³ and that the cervix might not be responsive to digital stimulation), she was careful to check how the mother was reacting to her explanation and attempted to diminish the opposing view by exhorting the mother to prove her wrong (p4L10 FN 14Jun06). This demonstrates reluctance on the midwife's part to explicitly overrule the woman's view by recourse to professional authority.

The issues of power and authority as a consequence of the status of the professional will be discussed more fully in chapter seven. In relation to birthing autonomy and the mother-midwife relationship however, these counter examples begin to capture the tension between the roles a midwife performs in that relationship.

Summary

This chapter has considered the concept of 'being with women' as the central philosophical principle underpinning midwifery. The 'being with' describes the immediate relationship between the mother and midwife. That relationship is not passive but engaged, and has the deliberate function of enabling the woman's birthing autonomy. Several apparent counter-examples were discussed and their meaning explored. Promotion of birthing autonomy is an ideal that appears in independent midwifery rhetoric and which is demonstrated in their actions. There are many instances however when this ideal is demanding. Where an individualistic conception of autonomy would encourage seeing these demands as conflicts between the midwife's and the mother's autonomy, the concept of relational autonomy encourages deeper exploration of the issues and mutual negotiation of the ongoing relationship. Midwives experience the tension and live with the ambiguity of relational autonomy. Further exploration of the tensions arising in their day to day practice will provide the substance for critique of the power relations in midwifery and home birth beyond these specific one-to-one

⁶³ Bishop's scoring as a system to determine the ripeness of the cervix and other indications of likelihood to go into labour and thus suitability for induction of labour by artificial means (Stables 1999).

relationships. This experience of 'being with' must be considered in the macro-social context of the Irish maternity system.

Chapter Seven On professionalism

In this chapter I discuss professionalism because professionalism arises time and again in the talk of independent midwives. Professionalism is an issue of concern for them and, I believe, a dilemma for them because the demands of professionalism are in many ways in opposition to the other major aspect of their talk which is about ‘being with’ women. The last chapter considered autonomy in some depth and linked midwives’ evident concern for relationship with women, to the promotion of birthing autonomy, which is promotion of maximal control by women over their own birthing process. As such it was a consideration of where the power lies in the relationship between the mother and the midwife.

This chapter also has its basis in an analysis of power; the power of the professions. Professional power or status is the aspect of professionalism that will be considered in the first section of this chapter. In section two, I will explore the concepts of professionalism and professionalisation. I will distinguish between the two because I believe that while the attributes of professionalism are laudable, the claims to power and status of the professions are political and self-legitimising discourses of professionalization. Professionalization serves the profession whereas professionalism serves the people, the client, or the woman.

Having made this distinction I will, in section three, examine the main characteristics of professionalism; they are: knowledge authority, professional autonomy and service. In section four, I will then discuss the midwives’ own interpretation and experience of professionalism. I will seek to present evidence that ‘being professional’ is a key theme in the rhetoric of independent midwives. I will also aim to provide evidence that independent midwives practice what they preach in this regard and that they do indeed behave professionally.

Section One Professional power and status

Turner and Hodge (1970) explain how many analysts of professionalism have attempted to identify the traits of a profession, deriving such traits from the classical ‘learned professions’ of theology, medicine and law. Unsurprisingly the learned professions have these traits while other, newer or lower status occupations, lack some or all and can thus

be labelled semi professions. The motivation for this tautological exercise however, seems to be a recognition of the status and power of those professions and a desire to determine a mechanism by which other occupations might attain such status. Goode (1960) suggests:

‘subtracting the derivative traits such as high prestige, power and income from those which are sociological causal. The two remaining core characteristics are a prolonged specialized training, and a collectivity or service orientation.’ (Goode 1960:903)⁶⁴

It is however precisely the ‘derivative traits’ that make the denomination of profession attractive to any occupational group. A brief examination of the derivative trait of social prestige is I think appropriate because:

‘They [trait theories] tend to obscure the middle-class nature of codes of ethics, and the ways in which the professions also act as agents of social control.’ (Abbott and Meerabeau 1998:4)

and because of the very close links between the professions, and other indicators of social power and status.

Professionalism, class and patriarchy

Ann Witz (1992) and Richard Hugman (1991) both consider the connections between professionalism and class. Professionalism, considered from the perspective of a Marxist analysis of occupations within capitalism, reveals how class structures overlay professionalism as part of the processes of capitalist production and social reproduction.

‘The origins of the caring professions are placed in the context of capitalist and middle class concerns about the productive labour of the working classes.’ (Hugman 1991:20)

Rich, middle class, white men historically make up the majority of the professions and they are educated and socialised with their peers, other rich white men who attain positions in government and the legislature. This has established, for medicine

⁶⁴ Professional autonomy, or the right to self govern, as a significant characteristic of professions is not overlooked by Goode (1960), nor Turner and Hodge (1970) who cite him. The idea of governance overlaps collectivity and service, but I feel it bears separate consideration.

particularly, a firm stronghold in the most powerful structures in western society. It has been demonstrated time and again by Hearn (1982), Witz (1992), Reverby (1987) Hugman (1991) that political influence has served the professionalizing project of medicine, from its self-regulating status enshrined in legislation, to the continuing recognition of medical evidence as authoritative in litigation.

‘While commentators such as Freidson and Starr⁶⁵ recognise that professional authority is often essential to fulfil the demands of the therapeutic process, they argue that medical authority has gone far beyond this level, encroaching into areas for which medical judgement and expertise are inappropriate, demanding too many resources and exerting too much control and political power over health care delivery.’ (Lupton 2006:117)

Jeff Hearn (1982) considers particularly the influence of patriarchy in the development of professions. He conceptualises a view of professionalism as a patriarchal progression from a feminist social action through male participation and cooption, onto managerialism and thence to full (and patriarchal) professionalism. He takes midwifery’s usurpation by obstetrics as a particular example of this patriarchal professionalization process. Patriarchy, even when it sees itself as benign, has been identified as predicated upon a devaluation of women.

A gendered, that is, socially constructed differentiation and discriminatory valuation between the sexes has been challenged by very many feminist authors. The work of Carol Pateman in ‘The Sexual Contract’ (1988) captures the essence of the social separation of the sexes. She describes the division between the private and the public spheres and the simultaneous devaluation and yet indispensable nature of women’s work in the private sphere. This sexual division of the public and private spheres influences Anne Witz’s investigation of professionalization and gender.

‘[Her] focus is on the socio-political and institutional locations of male power in the public sphere, and the extent to which the institutionalisation of male power in this sphere provided a crucial resource in the key historical period of occupational professionalisation.’ (Witz 1992:36)

The patriarchal nature of professions and the effects of class and gender upon conceptions of professionalism and the processes of professionalization cannot be

⁶⁵ Eliot Freidson (1970), Paul Starr (1982)

overstated. Professionalism, that is the denomination of being a professional, is closely associated with power, prestige, social status and high income.

Section Two Professionalism and professionalization: An etymology

To profess means to affirm, acknowledge or claim something; it means to be admitted (to holy orders) by taking a vow. In the following progression of derivations, it can be seen that the avowal element becomes less central and the occupational understanding as based upon expertise becomes more ingrained.

A professor is one who professes opinion or principle, is a teacher.

A profession is an occupation requiring special training (especially the learned professions, law, theology, medicine); it is avowal or an avowal.

‘Professional’ is adjectival and describes something or someone suitable for or engaged in a profession. It means engaging in an activity as a means of livelihood that is associated with competence, skill or expertise.

Professionalism; the ‘ism’ suffix turns the adjectival back into a noun and describes the state, condition or characteristic of a doctrine (or prejudice); seen for example in usages such as Marxism or sexism.

Professionalize (ise)⁶⁶, (professionalization or professionalizing) turns the adjectival back into an action or processes. In this case, it is the process by which an occupation claims professional status. The word encompasses the processes and structures that support the status of the profession in society. It emphasises also the strategies and functions that strive to negotiate, expand and defend the scope of the profession and its membership.

As Turner and Hodge (1970) explain,

‘the main issues which have been debated in the study of professions and professionalization centre around the problems of distinguishing a profession from a non-profession, and of discerning processes of professionalization.’
(Turner and Hodge 1970:23)

⁶⁶ I have made the unusual decision to put professionalize only in the US form because visually ‘ism’ and ‘ise’ are so very close, and I want to emphasise the distinction between the characteristics of professionalism and the very different process of professionalization which has to do with active occupational power dynamics.

Thus examination of professionalism may be factorial and / or developmental. The former is an attempt to describe the qualities of professionalism, while the latter to describe the processes of professionalization. The description of the qualities of a profession gives a good starting point for analysis of the topic because the characteristics of a profession become the adjectival markers of 'professionalism'. It is however the processes of professionalization, the pursuance and maintenance of professional status by the professional body, that most seem to present themselves as being problematic for individual midwifery practitioners.

Section three The characteristics of professionalism

The concept of professionalism has a vast literature devoted to it. I will divide my consideration into three main parts entitled knowledge authority, professional autonomy and quality of service.

Knowledge authority

This part will examine the structures and mechanisms by which professions (particularly medicine) have linked their professional authority to their claim to special knowledge. It will then consider how this knowledge authority is expressed particularly in maternity services and birth.

Professional knowledge claims

The main component of professions' claim to authority is specialised knowledge through prolonged education and experience. What is the nature of knowledge in health? Medicine, as the dominant profession in health, has co-opted knowledge from many disciplines and occupations; examples are butchery and anatomy to surgery, and herbology and pharmacology to medicine (physic), and psychology and psychotherapy to psychiatry. Medicine has also utilised knowledge from the disciplines of mathematics (probability and statistics), epidemiology, physics (radiology), chemistry and biochemistry, but particularly from biology and its branches including haematology, parasitology, toxicology, genetics and many more. Abbot and Meerrabeau (1998:257) thus describe medicine as colonizing biology. Medicine, or at least a concern for human

health and welfare, might charitably be said to be the basis for the flourishing of all of these sciences. Such a charitable view of medicine however is undermined by the medical profession's jealous maintenance of supremacy and authority in the field of the health sciences. Such is their authority that only doctors may prescribe medicines, or order and interpret laboratory, radiographic and other tests upon humans.

University education

Although the results of scientific investigation may theoretically be available to all, university education is the structural means by which one attains and is accredited for skills of carrying out and interpreting scientific investigation. In health the emphasis is in the sciences rather than the arts, but with some increasing recognition of the humanities. Whatever the operating epistemological framework however, the access to and recognition of university education has been central to the exclusionary and demarcation strategies (professionalization processes) of the professions. The sexist exclusion of women from medical schools up to the turn of the twentieth century for example has been described (Ehrenreich and English 1978, Hearn 1982, Reverby 1987, Witz 1992). The move to third level education, has been part of the professionalizing strategy of nursing, midwifery and the allied health professions (Hearn 1982, Hugman 1991, Hughes 2006). Third level education and credentialisation are legitimising strategies for professional status through claims to specialised knowledge. It is the social power of these structures that serve most to signify professional status, but as many commentators have mentioned, professional socialisation has its drawbacks.

‘Terms like ‘clinical’, ‘academic’, and even ‘professional’ have understandably acquired connotations of distance, reserve and dominance, through such factors as exclusive education, privileged knowledge bases and technical expertise. But these connotations are also attributable to professional socialisation programmes which result in adopted and learned modes of professional conduct, and which commonly encourage maintaining professional distance, and also to professional bodies which promote the respect, status and market share of their professions.’
(Higgs and Titchens 2001:10)

This aspect of professional distancing is a recurrent theme in midwifery writing and will be revisited particularly in the discussion of the tensions of the professional midwife and

woman relationship. Before leaving the concept of knowledge power, I wish to consider other sources of knowledge in practical professions.

Practise experience and expertise

Professional education is not entirely academic and consists of considerable periods of practical / clinical exposure, support and teaching.⁶⁷ Although a professional practitioner is deemed competent at the point of registration, the benefits of experience are self evident and seniority and authority are associated with extensive (breadth and duration) clinical /practical experience. Jamous and Peloille (1970) introduced the concept of the Indeterminacy: Technicality (IT) ratio in conceptualising professionalism. The technical aspects of an occupation are those skills or practices that are relatively closely defined, are operational, and which are understood to be predetermined in their mechanism and usage. Indeterminacy describes those aspects of work and skills that cannot be easily predicted and therefore require a degree of imagination, creativity and drawing upon previous exposure to similar but different situations. They thus require adaptation of and application of a range of knowledge in a variety of circumstances. Higher levels of indeterminacy, which involve skilled clinical decision making autonomy and judgement, are identified as being more professional. Technical proficiency, though essential, is accorded lower status by being more instrumental and less cognitive. In practical professions, physical touch interventions and communication might be viewed as entirely technical, utilitarian or functional. To do so devalues human communication and touch. These skills are not separable from their very real cognitive processes of ascribing meaning and interpretation. Communication is obviously central to relationship and birthing autonomy. Touch too has a strong therapeutic as well as diagnostic value in midwifery (Kitzinger 1997). To reduce knowledge to cognitive functions only, is to lose embodied knowledge (of the mother or the midwife) and is an unwise rejection of resources. Belenky et al. (1997) and Gardner (1993) discuss the idea of different

⁶⁷ European Union requirements for midwifery education include a minimum number of births to be attended (40) and minimum periods of practice in antenatal, labour and postnatal care. These are spelt out because of the usually disjointed, compartmentalised model of care seen in so many maternity institutions. A case load or continuity model of care would not need so explicit a prescription of aspects of care as care would be delivered throughout the childbirth experience.

knowledges and intelligences that have been woefully disregarded by a narrow epistemology associated with technical rationality, science and professionalism.

Specialism, hierarchy and the co-option of technology ⁶⁸

Jamous and Peloille's work (1970) therefore demonstrates the dominance of the academic, of specialised knowledge in professional authority. Their work also underpins the tendency to specialism (specialisation) among the professionals. Specialism, and demarcation of some activities as non-special, in the further refining of professional knowledge and education, leads inevitably to the demotion of usual or general skills to the level of the technical. Hugman (1991) talks of managerial or hierarchical chopping up of the role and the deskilling of the lower cadres. Citing Braverman (1974), he uses the word 'proletarianism' to describe the creation of semi and unskilled cadres.

Hierarchical structuring therefore arises from a tendency to occupational specialisation and role demarcation inherent within professionalization and the search for higher professional status (Witz 1992). Technological advances also form a means for professionalization, with professions keen to incorporate new technologies into their practice and to maintain their relative status by forbidding their use by others.⁶⁹ This echoes the co-option of knowledge from other disciplines to medicine. The maintenance of medicine's control over the use of that knowledge and of technology demonstrates again the close link between professional power knowledge and professional status, with the one supporting the other. Eugenia Georges (1997) considers one particular item of technology in the armoury of professional power and says:

'By reconfiguring the way women first sensually apprehend the 'reality' of their pregnancies, I argue that ultrasonography can act as an especially potent facilitator in the production and enactment of authoritative knowledge.' {Georges 1997:93)

Each of these examples of knowledge / power, the hierarchical dominance of the cognitive over the technical, university credentialisation and the co-option and control of

⁶⁸ Technological discourse was also discussed in chapter five, section one.

⁶⁹ The inappropriate use of technology in birth has been described by many writers including Murphy-Lawless (1998), Edwards (2005), and Martin (2001). One midwife directly challenges the appropriateness of technologies in her experience: 'I find babies recover a lot better on mothers than on a machine without any stimuli, that is [not] in any way encouraging them to stay in this world (p29L13 Int 21Feb08).

technology, are examples of professionalization, that is the claim of professional superiority, becoming enshrined in the structures of power in society. Foucault (1978, 1980) described the *mechanisms* or processes of knowledge / power (see chapter two); this section so far has described some of the *structures* of knowledge / power. The following paragraphs consider the *effects* of knowledge / power, particularly in childbirth.

Authoritative knowledge – the effects of knowledge power

The effects of knowledge / power in the development of the health professions are made visible in Foucault's history of medicine ('The Birth of the Clinic' 1973) and in various histories of the midwifery profession (Arney 1982, Donnison 1988 and Witz 1992). These are histories of the professionalizing project of medicine in its trajectory towards professional dominance in health. The relative fortunes of the other professions and their professionalizing strategies are, almost inevitably, constructed in relation to the fortunes of medicine.

Brigitte Jordan (1992, 1998) describes the effects of knowledge (and its power) in contemporary settings. She proposed the idea of authoritative knowledge, knowledge that is involved in decision making and which results in action. Jordan explicitly avoids determination of the correctness of knowledge and examines only its power, its expression.

'It is important to realize that to identify a body of knowledge as authoritative speaks, for us as analysts, in no way to the *correctness* of that knowledge. Rather, the label 'authoritative' is intended to draw attention to its status within a particular social group and to the work it does in maintaining the group's definition of morality and rationality. *The power of authoritative knowledge is not that it is correct but that it counts.*' (Jordan 1998:58)

'I specifically do not mean the knowledge of people in authority positions' (Jordan 1998:58)

Jordan's authoritative knowledge therefore is a description of the effects of knowledge power. The effects of knowledge power are what are described in the experiences of the independent midwives (and women seeking home birth in Ireland) outlined elsewhere in this thesis.

Authoritative knowledge in childbirth

Robbie Davis-Floyd and Carolyn Sargent (1997) edited a book called 'Childbirth and Authoritative Knowledge' in which collection Brigitte Jordan contributed. Together the contributors examined Jordan's (1992, 1998) idea of authoritative knowledge in the field of childbirth. It is interesting that in their introduction, Davis-Floyd and Sargent describe independent midwifery and home birth as the most 'heretical' contestations of hegemonic technobirthing. They are heretical because they contest the dominant maternity service model. They are a lived alternative to the operations of professional power seen by Jordan in her original observations in a United States delivery ward (and so very recognisable to those familiar with the Irish maternity setting). As has been argued in the chapters in this thesis on relationships and on autonomy, independent midwives have a commitment to a different relationship, one that does not assume epistemic authority over women's knowledges and experiences. Independent midwives strive to support the mothers birthing autonomy and in so doing are breaking the patterns of professional dominance which have been demonstrated in this section as predicated upon superior knowledge.

Browner and Press (1997:114) examine antenatal education and they identify that women construct their own knowledge deciding 'which medical advice to incorporate into their own health care practices and which to ignore', so the professional's expertise is not automatically accepted. They continue however that there is a tendency to 'acquiesce' in birth, with an 'unwillingness to trust embodied knowledge in childbirth' (Browner and Press 1997:126). As Szureck in the same volume (1997:293) puts it, 'Fear is quite enough to sweep the majority of women willingly and obediently into a hospital for birth'. The play of professional authority in home birth is therefore quite different than in the hierarchical and disempowering atmosphere of the maternity hospital setting.

Even in the dominant system however simple deference to professional authority (be it obstetric led and / or midwifery delivered) is being somewhat tempered by a greater appeal to evidence rather than simple authoritative decree (Enkin et al 1995, Goer 1995). This opens a means for midwifery and mothers' own utilisation of research evidence to

inform their choices and actions. Evidence based care brings a more democratic potential to the field but the hierarchical and structural context still pervade.

The next section considers the second characteristic of professionalism, that is, professional autonomy.

Professional Autonomy

‘The classic professional, because of superior knowledge, will claim autonomy and self-management, arguing that practice cannot be regulated by those not versed in the requisite knowledge bases. Each professional must be self-regulating and peer review is the only appropriate form of monitoring. The corollary of this is that the professional bears a heavy weight of responsibility for decisions made.’
(Davies1998:194)

If professional status is predicated upon a claim to specialised knowledge, knowledge alone is not sufficient. Self regulation is the other significant power of a profession; it is the combination of the two with a service ethic which defines a profession. Oleson and Whittaker (1970) suggest professionalization suited the needs of industrialisation in nineteenth century England and the United States. Professions’ expertise was utilised by the state and in return their professional autonomy was bolstered by statute supporting self regulation.

The hunt for professionalism amongst nursing, midwifery, social work and the allied health professions would seem to be a search for the autonomous control of their own practice, which comes with the status of ‘full’ professional.

Aspiring for social status however is problematic for the non medical health professions given the hierarchical nature of the health services, particularly within the hospital. The relative social status, of doctors and nurses for example, plays out in both the institution and in broader society. The general principle of professional autonomy, expressed as self regulation, nevertheless still applies whatever the perceived or actual hierarchy between ‘competing’ or overlapping professions.

What constitutes professional autonomy ?

The statutory power to self govern leaves the profession in control of its professional education, registration, discipline and removal from the register of members. These are significant powers because they give the profession considerable freedom to define the scope of their practice without interference from others. In return for, or to balance this degree of state non-interference in their practice, the professional body must take responsibility for ensuring its public accountability. This is sometimes worded as protection of the public or public interest.⁷⁰

Professional self-regulation regarding admission, education and registration

A profession's power to regulate its own education and training has, to an extent, been addressed under the section on epistemic authority. Education is not only about imparting knowledge and examining competence but also in very large part about socialisation into the norms and expectations of practitioners (Oleson and Whittaker 1970). The attitudinal aspects of professionalism are subject to the same normativising effects already described by Foucault (Discipline and Punish 1978). Marsden Wagner (1995, 2007) uses another term to capture the same normativisation. He calls it orthodoxy. This is the term he uses to highlight the power of the professional body to enforce compliance in its membership to forward the aims of professionalization over and above other service, individual or relational concerns.

Although final admission to membership requires candidates to complete courses of preparation and to pass examinations, by and large in Ireland the selection of candidates is no longer within the power of the profession. Candidates for the professions were, at one point, interviewed before selection. This controlled the admission to the profession to those deemed 'suitable'. The grounds for such suitability might well have been other than on their academic abilities alone. Classist, sexist, racist, even ageist attitudes in the

⁷⁰ The power of professions to self govern, instituted in statute, is being steadily challenged, or at least moderated in recent years by moves in Irish legislation regarding the professions. Legislation on the makeup of the regulatory bodies of pharmacists, dentists and medics, and in proposed legislation for nurses and midwives, seeks to ensure a majority on their regulatory boards of non-professional or lay members. This strategy to improve the accountability of the professions to the public is consistent also with moves towards equity, fairness and transparency (Department of Health and Children (2001 a).

selection process may openly or unacknowledged, have bolstered the norms, expectations and social status of the profession (Hearn 1982, Reverby 1987, Hugman 1991). The effects of class and gender in professionalization have already been discussed and selection of candidates is a significant gate keeping mechanism. In Ireland however the (leaving) examination points system at the end of secondary schooling, has become the main selection mechanism for candidacy. Students select the course they prefer and if they obtain good enough academic results they may be accepted on the course. This has the benefit of promoting an academic meritocracy (contestation of the discriminatory nature of the secondary level education and examination system aside) but limits the profession's degree of control of the candidate selection process. As a midwife teacher, I share some concern over the loss of professional selection of candidates into midwifery education. The school examination points system as the primary access to midwifery (or any profession's) education severely limits the access of candidates with broad life experience and demonstrable commitment to the central values of midwifery.⁷¹

Discipline and removal from the register, the responsibility for ensuring public accountability

After registration (and licensure) as a member of the profession the other powers of the profession over its membership come into effect. The issuing of guidelines for practice is a means by which the profession sets out its stall in relation to its functions to protect the public. It is both a claim to ethical conduct and a means by which the profession can demonstrate its self-regulatory function and hold its membership to account. An Bord Altranais' (ABA 2000b) code of professional conduct for nurses and midwives, and midwifery standards documents serve these functions. As the regulatory body, any complaints of unprofessional practice come before ABA. After preliminary adjudication a fitness to practice hearing (in camera, with full legal representation) may be instigated, where the powers of the ABA to discipline or remove the individual practitioner from the register may be enacted. This is a considerable power and responsibility of the ABA and is at the core of the profession's claim to professional autonomy. Public (or state)

⁷¹ At a national meeting of midwives and midwife educators to consider the educational preparation and support for Advanced Midwife Practitioners (AMPs) (Begley et al. 2007), this sentiment was widely expressed.

confidence that the profession is indeed self regulating hinges upon this function to back up the rhetoric of their codes and guidelines.

Protecting the public or enforcing orthodoxy ?

Governance, regulation and control are all words imbued with connotations of power and speak of a power relationship between the profession as a body and its individual membership. Professional autonomy extends from the profession as a whole to the autonomy of individual practitioners. This is seen most readily in the use of guidelines rather than strict prescriptive policies in professional practice. Guidelines maintain the IT (indeterminacy: technicality) ratio mentioned in the discussion of knowledge power in the professions. The professional is presented as more than a mere technician; it is argued that the professional must make complex decisions in complex settings and must have freedom so to do.

Wendy Savage's book 'A Savage Enquiry' (1986 and 'Revisited' 2007) details her treatment at the hands of her obstetric medical colleagues and her profession. She was struck off the medical register, but after considerable legal process was reinstated. Her story is paralleled by very many incidences in midwifery, including in Ireland the case of independent midwife Aine O'Ceallaigh. Aine O'Ceallaigh faced an ABA fitness to practice hearing, and in the interim was prevented from practicing midwifery. She had to resort to the high court to reverse the decision.⁷² Marsden Wagner (2007) in his contribution to Wendy Savage's book argues that the Savage case and so many of the cases involving midwives of which he has become aware, are instances of the struggle for professional control over birth.⁷³ He articulates very strongly that the processes of professional regulation need to be examined to reveal who has to gain by the proceedings. He said it must be considered whether or not these proceedings might be evidence of the professions' enforcing orthodoxy in the control of birth by professionals, rather than

⁷² For a summary of the case, the Ann O'Ceallaigh (Ann Kelly) Support Group: Fighting to keep homebirth a choice in Ireland, is still accessible on line <http://www.iol.ie/~raydj/Ann/summary.htm> accessed 5th September 2009

⁷³ One midwife aligns the rise of active management and obstetric control over birth in the eighties and nineties as concurrent with this witch hunting of independent midwives. 'It was at this time that active management [of labour] really swung in to place' (p29L26 Int 21Apr08).

evidence of service to women which obstetrics and midwifery claim. Wagner thus articulates a professionalizing influence in the operation of self-regulation and the power to remove practitioners. Professionalization is the process of ensuring professional power. Professional autonomy it seems is a means, a process by which to maintain professional status.

Documentation as self-governance

Foucault's (1978) techniques of power, which are monitoring and surveillance, can be seen in the use of documentary evidence in the holding to account (accountability) for actions at fitness to practice hearings.

'He who is subjected to a field of visibility, and who knows it, assumes responsibility for the constraints of power; he makes them play spontaneously on himself; he inscribes in himself the power relation in which he simultaneously plays both roles; he becomes the principle of his own subjection. (1978:202-203)

Poor documentation, or the lack of documentation, can be used to indicate the practitioner has failed in their self-monitoring and in their ability to account for their actions. Contemporaneous documentation is privileged over verbal accounts after the fact.

Normativisation, is seen in professional socialisation which is used to maintain orthodoxy amongst any profession (Oleson and Whittaker 1970, Higgs and Titchens 2001). If, as Wagner suggests, a will to control birth is embedded in obstetric orthodoxy, then giving of power back to women (by obstetricians or midwives) is liable to professional backlash. The power of the professional body is enormous. Independent midwives face the power not only of the obstetric profession, but also of their own profession and its orthodoxies; which have in turn been influenced by the structural domination of obstetrics and its practices in birth. The autonomy aspect of professionalism is thus a significant aspect of the experience of the independent midwifery practitioner in Ireland.

Service: professionalism and the claim to an ethic of service

The 'professing' or avowal element, seen in the etymological derivation of professionalism, is still visible explicitly within the clergy, but also in law and medicine

with their oaths, and in their appeal / claim to ethical codes of conduct.⁷⁴ The professions are service occupations and Turner and Hodge (1970) argue that the claim to rectitude and a service ethic may in large part be rhetorical devices to secure occupational recognition and status.

The claim to a service orientation is bolstered by charters and codes of ethics which

‘are notable for their relatively high levels of abstraction, which can be linked with substantial ambiguity over the level of action.’ (Turner and Hodge 1970:29)

Codes of ethics are fundamental to the health professions’ legitimising claim to service. An Bord Altranais (2000b) has a code of professional conduct, but in common with other regulatory bodies, the claim to ethical practice is somewhat at odds with their role ‘to protect the public’, as presumably that protection is from their own membership. Thus the ethic of service and the power of self-governance are closely interlinked; the rhetoric of each supporting the other.

New and Old professions: from service ethic to quality assurance

Roslyn Hughes (2006) in her PhD study about social work in the armed services in Australia, reviews professionalism and distinguishes between old and new models. She compares older models of professionalism (based upon the ‘learned professions’) and new professionalism. The latter she describes as being formed in the context of global capitalism. In Hughes’ new professions, the client (childbearing woman) is conceived of as a customer of care, and caring is presented as a commodity. Hughes argues that this leads to a different construction of the power relationship between the professions and those whom they serve. She begins to unpick the effects of commodification, managerialism and consumerism on professions or on occupations claiming professionalism. Each of these effects have been discussed by writers such as Hoschchild (1983 and 2003) and Hunter (2001, 2004 and Hunter et al. 2008) on emotional commodification, by McKnight (1994) on the construction of community service users as clients rather than citizens, and by Hughes (2006) on managerialism as the new hierarchy within health services.

⁷⁴ Perhaps the most iconic was doctors’ Hippocratic oath which carried with it the clear message of service and moral rectitude.

Attributes of contemporary (or new) professionalism which are based upon managerial quality assurance language have become the predominant attributes in the discourse on service. Hughes' new professionalism is about being courteous, discrete, efficient, predictable, and guaranteed or insured. These are all aspects of contemporary business quality assurance and managerialism. As Hughes puts it,

‘Professional practice is increasingly controlled and evaluated not by those within the profession but by managers via competencies and by customers through market principles’ (Hughes 2006:24)

or alternatively by Castel

‘The relation which directly connected the fact of possessing knowledge of a subject and the possibility of intervening upon him or her (for better or for worse) is shattered. Practitioners are made completely subordinate to objectives of management policy. They no longer control the usage of the data they produce. The manager becomes the genuine ‘decision maker’.’ (Castel 1991:293)

The measure of a profession it seems is no longer the epistemic authority of old. The claimed service ethic has become now the business language of managerialism and of quality assurance. Consistent product and customer care etiquette have become the markers of any service industry.⁷⁵

Social anthropologist Robbie Davis Floyd and sociologist Christine Johnson (2006) are optimistic and speak of ‘qualified commodification - a successful effort to commodify and market midwifery within the legal system without compromising its essentials of autonomy and woman-centeredness.’ (Davis Floyd and Johnson 2006:18).

The service ethic and neoliberalism

The Celtic tiger symbolised the influence of economic (neo) liberalism in Ireland, in the past two decades. Self-interested choice, in a contract society, is the basis for global capitalism. Acceptance of the neoliberal principle has an effect upon birth choice (indeed upon all health policy) in Ireland. Maev-Ann Wren (2003) writes about the tendency of

⁷⁵ The consequences of seeing birth from a consumerist perspective is that the expectation of the ‘perfect’ product and compensation for damaged goods is all too consistent with such a perspective. In a world where ‘you get what you pay for’ and where insurance covers the rest, it is little wonder that the birth machine has become what it has. Some discussion of insurance follows in chapter nine.

Ireland towards a privately funded health system akin to that in the US. This has consequences for the professions that provide health and maternity services. In Ireland private payment for birth services has always been the norm for the affluent, and even now, at last, when free maternity services are available to all, many continue to choose private or semi-private obstetric care. This may be in the hope of avoiding the indignity of busy antenatal clinics with no continuity of care. Women may be lured by the possibility of a private room postnatally, access to which consultants have the monopoly. The financial rewards of being the dominant profession in birth in Ireland are huge. There are also financial rewards for independent midwives if they choose a private care model. I believe however that professional competition over the financial benefits of maternity services is not the real source of inter-professional rivalry between obstetrics and midwifery. Private obstetrics is not threatened financially by home birth. Home birth and independent midwifery however challenge the absolute authority obstetrics has over maternity services in Ireland. It is this challenge to professional supremacy, I suspect, that is the crux of medical antipathy to home birth and to the midwives who support it. Professional boundary disputes between obstetrics and midwifery hang upon definitions of normality and abnormality in childbirth as has been discussed in earlier chapters. Neoliberalism and a business approach to professional services are at the heart of a change in the professionalizing project in the professions. As Murphy-Lawless (2006) points out however the rhetoric of choice is not only subservient to economics and managerialism, consumerist discourses are irrelevant for the poor who cannot afford even the circumscribed choice made available to the affluent.

It seems that Hughes' new professions and new professionalism arise as a response to the neoliberal agenda but they hardly challenge the power structures that underpin the old professions. The new professionals and neoliberalism use a language of service, quality and choice but like the old professions leave unchallenged, indeed even exacerbate the real disparity in power that comes with money and resources. Rather, Hughes demonstrates, that the old privileged status of professional has become transformed and co-opted into globalising systems.

Christa Craven (2007) argues that appeals to consumer power in the open market is a strategy that may suit the affluent middle classes, but which does not assist the poor who have no access to health insurance. Indeed their social concerns and limited choices regarding reproduction and parenting are not at all advanced by neoliberal appeals to choice predicated on spending power.

‘Providers, policy makers, and the population at large absorbed the ideologies that the pursuit of self-interest is the highest form of ethics, that competition is the motor of society, that productivity and economic growth are society’s most important goals, and that the market has spoken – and has blessed medical inequity, if not inflation.’ (Perkins 2004:161)

Professionalism therefore in either its patriarchal or neoliberal guises, hardly seems propitious for midwifery. Professionalism still holds the coercive power of the professional body and the professionalizing project over the individual autonomous practice of the midwife and over the birthing autonomy of the woman. As has been suggested in the earlier examination of autonomy, a relational autonomy model may apply beyond the promotion of individual birthing autonomy and be a model by which individual professional autonomy might genuinely be supported. The strength of the mother-midwife relationship builds individual birthing autonomy, perhaps an alliance of women and midwives working together in the promotion of home birth, could hold the key to autonomous midwifery practice.

‘It is in this context also that the ‘service ethic’ claimed by professions stands as a critique of professionalism. To the extent that orthodox professionalism, integrated in current organisational patterns of service provision, excludes the service user from the active definition and structuring of ideas and practices and so creates the role of client/patient as a passive object of its work, then the interests of the professionals have primacy which contradicts the ethic of service.’ (Hugman 1991:223)

Melissa Cheyney (2008) examines macro-social systems and presents home birth (and by extension home birth midwifery) as systems challenging praxis, that is a conscious and active challenge to the oppressive and dehumanising effect of systems. Old professionalism and professionalization is diminishing to women and to midwifery, new

professionalism, with its business ethic and managerial systems, does not seem any more likely to promote birthing autonomy.

I leave this section on professionalism now and, thus armed, I move forward with a description of how professionalism is experienced by the independent midwives. As with the concept of autonomy presented earlier I need to demonstrate not only that professionalism presents in the midwifery rhetoric but also in their practice. The challenges that professionalism (but more particularly professionalization) presents for independent midwives will become clear in the dilemmas midwives experience in their practice. For the present however only the rhetoric and practice evidencing commitment to professionalism will be presented.

Section four Professionalism in independent midwifery

Professionalism in independent midwifery rhetoric

Independent midwives very evidently want to be seen as professional, and to present themselves as professional. They refer to their education (training), that they are registered (licensed) to practice, and that they are legislated for in Irish statute as being allowed to attend women in childbirth. They are also aware and draw upon the fact that midwifery is internationally recognised as a distinct profession. They refer to the Nurses Act (1985) and ABA and dislike the definition within Irish statute of the midwife as a nurse and midwifery as nursing (see chapter one in the section entitled situating midwifery). They have made submission to the Department of Health and Children (DoH&C) on the forthcoming amendment to the 1985 Nurses Act (soon to be the Nurses and Midwives' Act) and look forward to the distinction between nursing and midwifery being enshrined therein. The autonomy of a profession to be self-regulating and for home birth midwifery to be self regulated is a strong theme in the talk of the independent midwives. Some who have been subject to fitness to practice (FTP) hearing with ABA emphasise the make up of the FTP panel arguing that non-midwives are not appropriate to judge midwifery practice. They argue also that midwives without community or home birth experience do not appreciate the demands of the situation (p1L18 FN 21Sept08, p3L41 Diary 29Jun09).

Independent midwives make very many references to their being cautious, conscientious, conservative and careful in their practice (p6L43 and p7L37 FN 21Sept08, p5L8 Diary 10Nov08). They talk of the importance of updating their skills and knowledge and refer to occasions when that have and plan to do so (p8L49 and p17L22, FN 20Nov06, p4L31 Diary 15Mar07, p4L20 FN 11Jul08, p15L19 FN 20Nov06).

They also refer to their scope of practice and whether certain activities (such as breech births) are or are not within their scope (p5L23 FN 21Oct07, p2L46 FN 21Sept08).

They are aware too of the need to be accountable for their practice (p6L32 FN 11Jul08) even admitting at times to certain defensiveness in their own practice (p3L23 FN 18Sept08). They acknowledge the need for audit and review of their practice (p5L19 FN 29Sept08, p7L5 FN 15Sept08, p8L18 FN 15Sept08) with some mentioning they already practice personal audit, submission of audit reports or, in the context of the Cork scheme, peer review (mentioned previously). So autonomy (self-governance) is a characteristic of a profession and the processes of review, audit and accountability are part of independent midwifery rhetoric and practice.

The independent midwives also give some critique of old professional values (Hughes 2006) by declining the idea of professional distance (p6L22 FN 11Jul08, p7L1 FN 11Jul08). At the same time they value their skills and expertise articulating that these can be difficult to maintain in hospital (p4L34 Diary 28Aug06) but also that they are undervalued (p5L45 FN 15Sept08). The midwives also feel that they need recognition for their knowledge and experience within the mother midwife relationship with one saying 'I can't work with someone who won't take advice over the phone or who won't do what I have asked or advised' (p7L10 FN 18Sept08).

Professionalism in independent midwifery practice

As has been already suggested, when describing the relationship between the mother and the midwife, there are many examples of midwives showing great respect and courtesy to the women with whom they work, particularly in relation to giving information and checking that the mother consents to any interventions (p1L32 FN 27Jul07, p7L26 FN 15Sept08, p6L5 FN 15Sept08). Courtesy and respect are also seen in actions such as

ringing up to say exactly when the midwife is arriving for a planned appointment or that she is running late. Liaison with other health professionals has also already been mentioned where midwives make efforts to maintain communication with hospitals, GPs, PHNs throughout the pregnancy. Transfer to hospital in labour is a particularly trying time for all concerned (and will be discussed later) and some midwives are especially careful to liaise closely with their hospitals where transfer looks likely (p4L13 FN 24Apr07).

As with their emphasis on being careful practitioners, independent midwives constantly refer to evidence based practice and their use of it (p7L13 and p7L29 FN 29Sept08, p1L31 FN 16Oct08). On occasion they have rejected the appropriateness of the evidence (p4L43 FN 19Feb08), or have expressed disenchantment with the scientific paradigm ‘Science and logic are all very well but they lose something’ (p4L9 FN 19Feb08) and ‘I believe in experience rather than in the written word’ (p6L15 FN 21Sept08).

Reservations that midwives have about blanket application of guidelines are explored more fully later in chapter eight.

Documentation is recognised as part of the professional record (p5L37 FN 21Oct 07) but as mentioned above, is often cited as part of the need to defend one’s practice (p4L40 FN 21Sept08).

Other examples of midwives attempting to add value (or quality) to their service to women (p31L31 Int 17Aug06) include offering complementary therapies such as massage or homeopathic remedies as part of their service (several of the midwives have formal training in these therapeutic methods); many provide a library of pregnancy and birth books and videos to the women. Some of the midwives have put together collections of women’s stories about their home births and pregnancies which the midwives describe as a resource for primigravid women to consider their expectations of home birth or as trigger to ask questions and plan their own birth preparations. Many of the midwives carry information leaflets or copy research evidence from sources such as the Cochrane database, NICE (National Institute for Clinical Excellence) guidelines, or MIDIRS (Midwifery Digest) research databases. These may be on topics such as water birth, vitamin K supplementation for haemorrhagic disease of the newborn, anti-D

isoimmunisation prophylaxis and metabolic screening tests. The midwives also use these resources to inform themselves, and the parents, about more unusual medical and obstetrical conditions that they may have to consider.

The most significant elements of professional quality in domiciliary care that women and midwives cite have been explored in the chapter on relationship (chapter four). These are the continuity of the relationship and the time spent together to build the relationship which in turn builds the woman's confidence in her ability to birth without intervention.

Counter examples ?

As in the consideration of the midwife's role in promoting birthing autonomy, so too here I have seen or heard of some examples of practices that might be considered less than entirely professional. Several midwives for example suggest fennel tea as a remedy for babies with 'wind' but without recourse to any evidence to support its use other than their opinion or anecdotal experience (p4L21 Diary 18Sept07). Similarly some have mentioned castor oil as a possible means of inducing labour when the woman is approaching two weeks post term gestation. This mention was however made with the caveat that there is no evidence to support it and the midwife therefore could not recommend it. My own interpretation of these examples is that the midwives, from their experience, believe that some intervention might sometimes work but that their claim to be evidence based professionals does not allow them to be seen to be promoting them. This is an example of where personal or professional opinion based upon experience becomes devalued or less authoritative than evidence based knowledge. At the same time the personal relationship between the mother and the midwife is such that the mother trusts the midwife's opinion and may well try their suggestion. The midwife, I believe, is acting defensively; defending herself from accusations of recommendation of non-evidence based interventions which would, since evidence is the basis for professionalism, be unprofessional. The acceptance of research evidence as the basis for professional behaviours creates these clumsy rhetorical devices 'I can't recommend X but' at the interface between defensible evidence based practices and (evidentially) indefensible experientially based knowledges.

Other examples exist where midwives seem aware of the potential for improving or assuring quality in their practices. Their desire to present a professional face means however that they do not explicitly admit to less-than-perfect practice. Examples of potential improvements that they have hinted at include correct securing of medical gases on transport to and from a birth and more rigorous (and documented) maintenance of items of equipment and drug storage processes. Sterilisation is another quality assurance issue of which many midwives are aware. Several have, but most do not have, access to hospital central sterile supplies departments to provide them with materials and services. Some therefore carry only sterile, single use, equipment, others use boiling to sterilise cord scissors for example, and still others use or share small autoclaves. The latter have commented that their autoclaves should really have a print-out record of time, date and temperature. This printed record facility is required in tattoo parlours for example. Similarly with placenta disposal some midwives have arrangements with their local hospital for their disposal but very many leave disposal to the mothers with warnings that disposal in public amenities is not acceptable. Deep burial or incineration in a hot Aga are suggested as means of disposal. (No one I spoke with reported the mother or parents eating the placenta though the idea was alive in mothers' imaginations.) Lack of structural support for independent midwifery in these areas, as in so many others, such as dedicated ambulance transport, obstetric or neonatal flying squad support and supervision mechanisms, therefore undermine the perceptions of independent midwifery work as professional. Midwives must overcome structural impediments to professional practice through a combination of their own ingenuity and chance relationships with sympathetic and supportive others.

Subversion

Sharples (2005) suggests three ways to work against an oppressive system: subversion, avoidance and confrontation. Subversion she says is exemplified by women smiling sweetly and doing their own thing until too late. This undermines the oppressive system but without effecting change. Avoidance of the system is possible. 'Midwives [by going into independent practices avoid oppressive maternity systems but] give up security and income and invite hostile attentions of the medical establishment.' (Sharples 2005:8) thus

they provide an alternative model. Unassisted birth is a mother's means of avoidance. However 'silence is complicity and doing nothing for change passively supports the status quo.' (Sharples 2005:9) She thus suggests the third category, confrontation; but for women 'the moment of confrontation happens at our weakest moment on enemy ground' (Sharples 2005:9). So women need advocacy, which is where the midwives have their role. Midwives, she says need to collaborate with women to campaign for change in maternity services.

Avoidance and confrontation as expressed in independent practice, and to a degree in midwives relationships with other professionals, have been outlined in chapter four and will be considered again in chapter eight. Subversion is a response that has not yet been highlighted in this thesis. Some examples of subversion, as means of dealing with structural impediments to professional practice and the lack of support for maternal choice in place of birth, are presented here. The most obvious perhaps is the response of mothers themselves to the withdrawal of bloods and scans in Dublin referred to in the introduction. Many mothers simply did not say they were having a home birth. This is hardly unprofessional on the part of the midwife, but collusion or promotion of such behaviour is hardly conducive to open and transparent liaison. In my own experience, my advice to a mother to be open about her intention led to her being berated by the obstetrician who threatened she would withhold scans if the mother persisted with her plan to birth at home. The mother's own protest and my contact with the hospital helped reverse that decision; but the case is an example of how subversion is encouraged by the system. Another example of subversion of the system includes using delaying tactics (rather than refusal) when hospital admission for induction of labour post term is routine rather than individually assessed. As a final example I would like to explore a phenomenon that has also been reported within hospital settings. It is the documentation of progress in labour as less than actual progress (for example in the recording of 5 centimetres cervical dilatation as 3cm, or fully dilated (10cm) as 8cm) (p22L50 FN 20Nov06, p37L25 FN 20Nov06). The logic, explicitly discussed (in my experience) amongst midwives in hospital and domiciliary settings, is to give the woman extra time before intervention for delay is instigated. This is a concept described by Mary Cronk as 'doing good by stealth' (2008).

If the midwife at a home birth is basing her assessment upon the woman and how she and the baby are coping with labour, as is the contention of midwives, whatever their context, then such subversion would seem an unnecessary exercise. That any independent midwife should continue to ‘massage’ the record demonstrates a sense that that record can be used to hold them to account and that the ‘true’ record would somehow be worse, (for them ? for the mother ?) because another reader’s expectation of action might find them ‘at fault’. Commitment to documentation of professional intervention forms part of ABAs professional code (ABA 2000b and 2002). It is apparent however that documentation may be something other than a record of exactly what happened. Contemporary notes are supposed to diminish after- the-fact variance with what actually happened and yet an awareness of future time, of the ongoing measurement of progress, and of future viewing of the record, seem to influence the documentation in the home birth setting as in the hospital setting. Falsification for records, (for that, at its baldest is what it is) whether provable or not, or with putatively good intent, is hardly consistent with professionalism. This practice is an act of subversion. It simultaneously acknowledges and removes the power of the partograph (the documentary record of labour progress) to determine the timing of intervention (as lain down by alert and action lines on the partograph) and puts it back into the hands of the midwife. The rhetorical justification is that it gives the woman (not the midwife) more time and thus more freedom and flexibility to birth without intervention.⁷⁶

The common use of water for labour and of waterbirth at home is an aspect of independent midwifery practice that has deliberately not been publicised in fora where

⁷⁶ My experience of transferring women into hospital in labour where I have felt cervical dilatation has been for example 5 or 6 centimetres, is that midwives, in a hospital with a strong history of active management, have recorded the same dilatation as 2 centimetres (p2L34 and p4L3 Diary 06Oct06, p2L20 and p3L2 Diary 01Sept 08). I have not taken this divergence as an insult to my own ability to determine cervical dilatation. I wonder however whether this is a practice of ‘doing good by stealth’ as described by Mary Cronk (2008) for the purposes of protecting women from intervention in a highly interventionist system. I wonder too whether this midwifery practice, of recording progress in labour on admission to hospital and to labour ward as significantly less than physical examination suggests, might inadvertently be colluding in and supporting active management by maintaining the illusion of its efficacy. Does this kind of doing good by stealth not rather prop up a system that promotes throughput and intervention at the expense of individualised, genuinely supported and intervention free birth? There is sufficient sociological evidence of normativisation and collusion in oppression (Friere 1970, Jordanova 1989, Honneth 1996, Martin 2001, Kirkham 2003c, Kirkham and Stapleton 2004 and Banks 2007) for the possibility at least to be acknowledged.

concerns, reservations, even objections to the practice might be expressed. This could be construed as politically astute or as deception. The latter interpretation allows the inference that the independent midwives themselves see something wrong, or unprofessional, about the practice. Neither they nor I feel this is the case, but the tactic of avoidance of the issue does seem to me to be another example of behaviour by an oppressed group (or group that feels vulnerable and under threat). It does not reflect the behaviour of a fully autonomous and professional individual or corporate body.

Summary

This chapter on professionalism began with a differentiation between professionalism, as the characteristics of a profession, and professionalization. Professionalization is a combination of the political manoeuvring of professions, relative to each other and to other occupations, and the justificatory strategies used in the pursuit of social status and professional power. The justificatory claims of professionalization reiterate the putatively positive characteristics of professions.

The chapter continued by discussing the three main characteristics of professionalism namely, authority, autonomy and quality of service. The basis for authority has been linked particularly to other social structures such as class and paternalism which have influenced the formation of the professions. The main basis for authority of professions has been identified with specialised knowledge and especially with science and the control of technology. Aspects of knowledge authority based upon experience and technical proficiency have been diminished and increasing reliance is placed upon scientific evidence as the basis for practice justification. The concept of authoritative knowledge, knowledge upon which decisions and actions are made, was discussed as an effect or an expression of knowledge's power. Midwifery knowledge can use the same basis upon evidence as other professions but, in privileging scientific knowledge in the pursuit of professionalism (professionalization), it silences other knowledges not so amenable to the scientific or professional paradigm such as embodied, emotional, interpersonal, communicative or intuitive knowledges.

Autonomy, the right to self govern is another characteristic of professions that was examined. Professional autonomy is problematic for midwifery in Ireland because of the

dominance of obstetrics within the structures of the State and particularly in setting the maternity services agenda. Midwifery's conflation with and subjection to nursing in Ireland (as discussed in chapter one) is a further impediment to midwifery autonomy. The professionalization of midwifery and nursing, their eagerness to demonstrate control of their own profession was proposed as an impetus for promoting practitioner orthodoxy, an orthodoxy predicated on professional (obstetric) control over birth rather than women's control over birth.

Quality of service in the old professions was expressed in a service ethic reflected in broad codes of ethics. This service ethic is the third characteristic of a profession and seems to have been replaced in new professions by an emphasis on a business model of quality assurance, customer service and consumer satisfaction.

The last section of this chapter revealed that independent midwives not only have professional characteristics (such as skill, an evidence base and self-audit) but also that they actively aspire to demonstrating that professionalism. Eagerness to appear professional however, subdues their promotion of some aspects of quality in their service, such as the significance of relationship and their use of complementary therapies. Lastly in this chapter, it was argued that structural domination of birth by obstetrics in hospital, seems to make subversion, which is a less than autonomous behaviour, a strategy that some midwives (and mothers) use for maintaining women's control over birth at home.

Taken together chapters six and seven lay the groundwork for understanding the dilemmas inherent in independent midwifery practice. These two intentions, the intention to support women's birthing autonomy and the intention to maintain one's professionalism seem often to be in opposition to each other. This opposition or tension is demonstrated in the dilemmas described in the next chapter.

Chapter Eight Independent midwifery dilemmas

In this chapter are described various complex dilemmas that independent midwives experience in their day to day practice. Unlike the logistical matters outlined in chapter three or the relationships outlined in chapter four, the issues raised in this chapter have a complexity that require more than a simple description to capture their essence. The dilemmas outlined in this chapter are instances in midwives' experience of contestation between their intention to support women's birthing autonomy (which was clearly articulated in chapter six) and the demands of professionalism (which were detailed in chapter seven). This chapter highlights that the intentions and trajectories (that is the paths of action required to fulfil those intentions) of birthing autonomy and professionalism are very often divergent. Thus the practice of independent midwifery is problematic and littered with moral dilemmas. This chapter will only outline the nature of the dilemmas, it will not yet link the dilemmas back to the principles of autonomy and professionalism. That discussion and analysis will be addressed in chapter ten.

Dilemma analysis as means to identify key issues

Winter (1982) proposes the identification and selection of dilemmas as a means for identifying the 'important' or 'significant' issues in interpretive research, especially where there is a significant amount of field data. He writes particularly in the context of action research, but the same principle can also be applied to the identification of foci for analysis within ethnography. Dilemma analysis derives from, and is an application of, dialectics (Bhaskar 1993). In dialectics, social situations are understood to be a product of interconnectedness, the particular connections in a social setting are described as making up the context. Social situations and relationships are considered to be in a continuous state of flux, an idea first proposed by the ancient Greek philosopher Heraclitus. Change, indeterminacy and contingency are therefore understood, or allowed for, in the description and analysis of social situations. The third aspect of dialectics which is particularly relevant to dilemmas analysis, and to this section of the thesis, is that opposing or competing interpretations or discourses about social phenomena is to be expected.

‘So the dialectical principle here is: we don’t understand something fully until we can see its contradictory elements.’ (Winter and Munn-Giddens 2001: 248)

Contradictory elements can present themselves as differences in opinion on a given topic. Certainly independent midwives are not homogenous in their opinions as will be seen in some of the following sections. The dilemmas analysed below are not however primarily about where midwives differ, but largely where they agree. They agree that the situations listed are problematic, and present them with difficulties. These are instances where either or any choice has negative consequences which they would ideally hope to avoid.

As with the derivation of categories in the largely descriptive first part of this ethnography, simple coding and aggregation of codes have been used to derive coherent themes or categories summarised into fundamental or common dilemmas.

The following dilemmas recur for independent midwives and capture the difficulties they experience in their practice. Each dilemma will be discussed more fully in its own section but for now a summary will attempt to capture the nature of each dilemma in a nutshell.

Women’s autonomy, Freebirthing and Duty of Care

Midwives want to promote women’s choice and birthing autonomy but find that at times their own personal choices and autonomy conflict with women’s. This is particularly so when declining to take women on as clients. The dilemma hinges upon the drawing of personal boundaries within a close personal relationship.

One consequence of declining to be a woman’s midwife is that she may choose to birth without professional support. The midwife knows that outcomes of unsupported birth are poorer than for supported birth and may even prove fatal. Declining requests for home birth can therefore be a dilemma.

Having contracted to be a woman’s midwife there is a duty of care. Midwives feel a moral duty to care even before a professional contract is in place. This is essentially the problem in accepting or declining care. The personal moral imperative to care, where

professional norms would suggest the midwife should decline to become involved, can leave the midwife subject to professional critique. The duty to continue to care once the professional contract has been initiated can leave the midwife professionally exposed.

Professional guidelines and professional autonomy

Professional guidelines strive to guide practice and yet maintain professional autonomy by not being prescriptive. Guidelines however can be flawed and easily assume the status of prescription in hierarchical settings. Independent midwives face structural impediments to autonomous interpretation of guidelines. They also perceive themselves as particularly vulnerable to professional critique arising from autonomous interpretation of guidelines. Guidelines on suitability criteria for home birth are cited as a particular example of this dilemma. Various responses to these dilemmas are possible but each brings their own subsequent dilemmas.

Transfer of care

The anticipation of an antagonistic reception from hospital maternity services can leave mothers and midwives reluctant to transfer to hospital care. This can exacerbate clinical decision making dilemmas at home birth.

Insurance⁷⁷

The expectation of contemporary society seems to be that indemnity insurance is essential for professional practice and yet for-profit insurance companies will not cover home birth. The lack of comprehensive insurance for autonomous independent midwifery practice leaves midwives having to decide whether or not to practice without it.

⁷⁷ Clinical indemnity insurance for independent midwives and home birth became a critical issue during the time of this ethnography. Private health insurance is an entirely different subject but also has a bearing upon independent midwifery practice. For clarity, and to make the concepts and chapter size manageable, insurance related dilemmas are treated separately in their own chapter (chapter nine) rather than with the other dilemmas here in chapter eight and in chapter ten.

The status of the fetus in Ireland

In Ireland the pregnant woman's bodily and moral autonomy is potentially contested by presence of the child within her. The contested, if not diminished, status of the pregnant Irish female might then be a dilemma for Irish midwives. Midwives might be considered as agents of the state in this regard and therefore be torn between that (professional) role and their commitment to the woman's birthing autonomy.

Politics & Reputation

The independent midwife must choose whether it is better to be a birth activist or remain quietly under the radar in her day to day midwifery practice. Each decision has its costs and benefits.

In the following sections each of the dilemmas listed will be considered.

An explanation will be offered as to how or why the particular issue presents itself as a dilemma for the midwives. The possible choices the midwife might make and the consequences of those choices will be outlined. That each option is problematic to some degree is precisely why the issue presents as a dilemma. The choices available are rarely resolvable by recourse to scientific data or objective evidence alone. There is a degree of evaluation of each potential outcome. Thus these are moral dilemmas requiring moral (and therefore contestable) decisions. The inability of science to answer moral questions has been argued elsewhere (chapter two, section five, chapter five and chapter seven, section three) and will be reprised again in the discussion chapter. The particular evidence on each matter with the dilemmas will not be dwelt upon. Nor will there be a judgment of the rightness or the wrongness of the decisions midwives make. These sections will simply identify that the issue is indeed a dilemma for the independent midwives and demonstrate that their responses can differ. This chapter and thesis will not give a close examination of individual dilemmas but rather attempt to analyse the general nature of the dilemmas independent midwives face.

The dilemmas

A dilemma: Freebirthing

Freebirthing – what is it ?⁷⁸

Freebirthing is the term used to describe deliberately professionally unattended birth, usually in the woman's own home. The woman may very well not be entirely alone and unattended, her partner, friends or family may be with her, but she has chosen not to engage the services of a recognised professional, doctor or midwife for the birth.

Professional jurisdiction for childbirth attendance

The law in Ireland does not forbid unattended birth, but it does explicitly say that no one should attend a woman in childbirth except a qualified doctor or midwife or a student undertaking such training (Section 58 of the Nurses Act, 1985). It is thus possible under that Act to prosecute those who are unqualified for attending a woman in childbirth. The act therefore explicitly promotes the professions of midwifery and obstetrics, with the statute accepting the claim to specialised knowledge of those professions to make childbirth safer. This recognition of the professions in statute may be little more than legally legitimised professional closure strategy and protectionism. Neither obstetrics nor midwifery contest the assumption that professional attendance provides better outcomes; enormous amounts of research resources compare different 'professional' interventions but rarely, if ever, consider non-professional, indigenous, or local women's birth practices in their comparisons. Indeed in 'A Guide to Effective Care in pregnancy and Childbirth' a precursor to the Cochrane research database of clinical trials, social factors such as culture, tradition, status, commercial pressures and even fashion are acknowledged as influences on birth practices that are not (sufficiently) focused upon in such research (Enkin et al. 1995). Professional (or at least trained) attendance at birth is promoted as part of the WHO policy on maternal and child health.⁷⁹ John McKnight

⁷⁸ I am grateful to one of the independent midwives who pointed out the use of the term 'freebirthing' can, for some, indicate fully intentional, completely solitary birth.

⁷⁹ WHO partner organisation, the Partnership for Maternal, Newborn and Child Health (PNMCH) <http://www.who.int/pmnch/about/en/> (accessed 12th September 2009)

Priority area 4 Strengthening Human Resources For Maternal, Newborn & Child Health (MNCH). Strengthening human resources capacity in countries – improving the number, skills and competencies of health care professionals, administrators and other local MNCH stakeholders. Achieving universal coverage of reproductive, maternal, newborn and child health services will require an

(1994) in his powerful critique of health service systems, derides the manner in which health systems can disempower communities and the citizenry from actively engaging and maintaining their own health. Vincente Navarro (1984) also questions the ideology of WHO policy makers and asks whether they consider the vested interests of international capitalism and the social elites of less developed countries (LDCs) in developing their policies. The assumption that professional models of birth might be appropriate for LDCs is one example where that ideological question may not have been asked. Like Marjorie Tew's (1998) critique of the assumptions about hospitalisation being the cause of lower, maternal perinatal mortality rates (in Europe and North America) in the mid twentieth century, the application of 'first world' approaches to birth in LDCs not been questioned. Automatic professionalization of birth in other contexts may be based upon ideological assumptions and not be empirically supportable.

Sandra Lane for example demonstrates that populations of poor women of colour in the United States have maternal mortality rates that rival and surpass some Poor World countries (Lane 2008). Notwithstanding these very macro-social questions and their international and humanitarian implications, in Ireland and in other highly developed countries with their well established health and maternity systems midwifery and obstetrics are, differentially, well established childbirth professionals who have excluded laypersons from childbirth practices.

Prosecution for unqualified attendance at birth, under the Nurses Act 1985 (and its earliest form The Midwives Act of 1918), is not known to have been brought in Ireland, but the possibility remains, and is highlighted to those proposing such a course of action as freebirthing. The independent midwives in their stories tell of instances when such prosecution has been threatened by public health officials after the event but that it was not pursued (see below). If a woman chooses not to disclose whether she had any birth attendant with her, prosecution would be virtually impossible. The outcome of the birth too may have some relevance. Where mother and baby are well after the birth there may

additional two million health care workers globally. This calls for concerted efforts among all partners to ensure the necessary training, deployment and retention of staff. Delivering any in-country strategy on improving MNCH will require not only additional numbers but also better human resource capacity. Integrated human resource plans will be developed as part of national MNCH plans to ensure that MNCH skills and competencies are addressed and knowledge gaps identified. As well, health care professional associations will be strengthened and more directly involved in national health planning.

be little incentive to investigate, and in any event, who has the authority to instigate such an investigation is not entirely clear. If a mother or baby were to die the case would be brought before the coroner. If a baby were to die or suffer handicap it would be difficult to determine that attended birth would have prevented it. If the mother were to die (or nearly die) it would be more scandalous given the very low maternal mortality rate in Ireland.⁸⁰ This would certainly attract more attention and probably include investigation of the circumstances surrounding the birth. Freebirthing thus lies considerably under the radar of state maternity services. It easily remains ‘invisible’ by simply not mentioning one’s intent; there seems to be no means to collate its incidence.

The following three extracts from my fieldwork indicate that freebirthing is an issue for independent midwives. It is an issue very closely related to their decision (autonomously / freely made, or perforce of circumstance) not to attend a woman for a home birth. As such it follows on closely from chapter six on autonomy and is one of the variety of dilemmas that arise from trying to accommodate women’s birthing autonomy.

From a field note:

One midwife tells the story of a Chinese woman who had no money and lived 40 miles away. The midwife (and other independent midwives ?) declined to take her on. She still chose home birth and was attended by doulas – but when the baby was born it needed resuscitation – ‘they got an awful fright’⁸¹ (p8L18 FN 21Sept08)

From an interview/ conversation: (A = midwife, Q = interviewer /researcher)

A And they [the health board region at the time] had had out of hospital, I mean unattended births, they had 2 casualties at the time, they were trying to prosecute the parents but that didn’t happen thank god.

Q The babies, sure babies die in hospital too. So were they blaming the parents?

A They were unattended births.

Q They made that decision to be unattended?

A Yeah.

Q Okay.

⁸⁰ WHO World Health Statistics, Maternal mortality, Ireland, 4 per 100,000 births (2006), 1 per 100,000 births (2008) <http://www.who.int/whosis/whostat/2008/en/index.html> accessed 12th September 2009

⁸¹ The particular vulnerability of this woman, foreign and poor and then also choosing birth without a qualified attendant is shocking. There was no suggestion that she was declined service for any of these reasons.

A And I was called to one and I didn't go out because I was busy with another case but the baby had drowned.

Q Oh flip.

A Yeah so it looked to me as if it was, had there been somebody who knew what they were doing it wouldn't have happened you know so that was obviously what pushed things along big time because it was so tragic and so sad.
(p5 L8 Int 21Feb08)

From a field note:

One midwife told of cases 'in Cork some years ago where PHNs threatened to prosecute women free birthing but that they had to back off'
(p2L35 FN 16Oct08)

Two other examples illustrate that the power of the state (through the actions of health professionals) in the areas of maternal and child health are not so restrained or constrained as in birth attendance:

A midwife talked of a story of a case in Donegal where a mother refused a metabolic screening test and child was then made ward of court under the Child Protection Act 2001, the test done and the child then given back to mother
(p1L28 FN 27Jul07)

From a research diary entry:

Midwife tells of her dilemma arising from being contacted by a rhesus negative woman in her second pregnancy who was refusing to have bloods and scans. The midwife felt obliged to decline as the potential risk of iso-immunisation when unmonitored put her outside the terms of the MOU. The woman was now threatening to freebirth. My suggestion that the midwife write to the director of public health and insist that the HSE provide support for the woman and the midwife to facilitate the home birth, was vetoed by several midwives. The argument was that the option the HSE might take was judicial review to force hospitalisation. It would be better, they argued, to use this case and this issue as an example to push for change through the local steering group.
(p2L41 Diary 02Apr09)

These last two examples and a judicial review allowing blood transfusion of a Jehovah's witness⁸² indicate the power of the state through its operatives, those in the health

⁸² A Jehovah's witness had clearly stated her refusal of blood products but at caesarean section obstetricians brought her case for emergency judicial review where the judge ruled she could be given a transfusion for the sake of the ongoing care of the neonate.

professions, to enforce compliance around reproduction, childbirth and child health. Midwives in accepting state recognition of their professional status (and state funding of their education and training) and their rights to practice may have to face the consequences, though usually not explicit, of their responsibilities as professionals as defined by the state in law. It might be argued that the autonomy of professional bodies includes a degree of autonomy in their relationship to the state in the performance of their professional role. They are thus not necessarily automatic functionaries of state. Separation of legislative and judicial powers also theoretically diminishes direct state control over professions and individuals. In the words of Michel Foucault:

‘the state is no more than a composite reality and a mythicised abstraction, whose importance is a lot more limited than many of us think. Maybe what is really important for our modernity – that is, for our present – is not so much the *etatisation* of society, as the ‘governmentalization’ of the state.’

(Foucault 1991:103 in Burchell Gordon and Miller 1991)

Even so, the everyday lived practices of the state make freebirthing deeply problematic.

Freebirthing – what is the nature of the dilemma?

The midwife is obviously sympathetic to the desire and choice for home birth but, given demand, cannot attend everyone requesting one. Personal and logistical reasons aside, and even without consideration of the restrictions and eliminations inherent in guidelines for the suitability for home birth, a midwife will be unable to attend some women looking for homebirth. The anguish this causes the mother and the pleading that can ensue can become part of the everyday experience of the midwife and can be distressing.

‘She begged me to take her on.’ p31L35 FN 20Nov06

says she took her on because she was so persistent. p1L34 Diary 12Dec07

General feeling though was that women who ‘really want’ a home birth will be

Irish Times Fri 09 Sep 2006 Judge orders hospital to give transfusion
<http://www.irishtimes.com/newspaper/ireland/2006/0922/1158590880865.html> Accessed 12th September 2009

Irish Times Sat 04 Apr 2008 High Court vindicates hospital's action on transfusion
<http://www.irishtimes.com/newspaper/ireland/2008/0426/1209158402682.html>
Accessed 12th September 2009

persistent and call back and back to try to secure one p6L14 FN 10May06

another woman whom she had delivered before from the islands who rented a house / room close by so that she would be no bother but to please attend her for home birth. p6L19 FN 10May06

Medical discourse has become the principle discourse around birth, and hospital birth is promoted as the only ‘reasonable’ choice. The next question or dilemma then, for there are dilemmas aplenty before this last one, is what to do with the knowledge that a woman intends freebirthing? A midwife’s belief in birthing autonomy supports the woman’s desire for birth on her own terms. The midwife also knows that qualified, professional attendance improves maternal and perinatal outcomes. The independent midwives all believe that women should be offered support by the State to have a professionally attended birth. The State, in this case is declining to provide such a service where the woman wants it.⁸³ Independent midwives believe that the health service (HSE) should be held to account for providing the service, and thus the dilemma is how to take that stand without further stressing the woman and indeed further jeopardising her freedom. To an extent the HSE, by expanding the home birth scheme to the whole country through the MOU and its associated clinical indemnification, has acknowledged the demand, and the moral, if not the legal, responsibility to attempt to provide that service or at least facilitate those who would provide it.⁸⁴ The HSE and its servants / employees however rarely proactively respond to a ‘theoretical’ need but rather are more inclined to be reactive. Some health board regions, for example Wexford, will make every attempt to accommodate women who decline hospital services. It has been known however for the

⁸³ Supreme Court decision O’Brien vs South Western Health Board (SWHB) (2003) stated that a health board is obliged to provide maternity services but is not obliged to provide home birth. It is interesting to see the doctor-manager of the health board’s assertion that view of his board is that consultant staff maternity units are ‘deemed’ to be safest, and that domiciliary services ‘could only be provided by registered medical practitioners’. These are stark examples of doctors’ power to influence decisions on health policy in Ireland.

⁸⁴ An earlier Supreme Court decision, *Spruyt and Wates v Southern Health Board (SHB)*, (unreported 14th October 1988) which decided there WAS such an obligation was the reason why the SHB originally provided their home birth service. It is through this remnant of a community midwifery service that independent midwife (self-employed community midwife SECM) supporting a home service is now funded under the memorandum of understanding (MOU) with the HSE.

HSE or their employees, to threaten women with judicial review. If the woman, in demanding service, says she otherwise intends freebirthing, she may be coerced to have a hospital birth 'for the good of the baby'. The protection of the unborn child, which is enshrined in the Irish constitution, is cited as a possible means to enforce hospitalisation. This constitutional dimension finds its way into the ABA code of professional conduct. Thus the midwife knowing of, or even suspecting an intended unattended home birth is in something of a dilemma.

The time scale and the attendant stress to the mother, exacerbate such situations requiring swift and possibly too hasty decisions that by no means are certain to find in favour of the mother's autonomy. The whole idea of choice of place of birth presents a dilemma that has, at its heart, an opposition between the needs and entitlements of the individual versus the widely held 'good' of the population, and where a hospital based maternity model is erroneously held to suit all.

The midwife as agent of the state, her professional status being endorsed by the state, is under pressure not to 'be with' the woman. The midwife is encouraged to diminish her relationship with the woman and collude instead in undermining the woman's birthing autonomy. Midwifery philosophy would tend to support individual birthing autonomy. Midwives recognise the negative effect a state and a dominant professions-sanctioned maternity service has on women's birthing experience and thus potentially on her whole autonomous parenting trajectory.

To summarise, the dilemma associated with declining to attend for home birth and the subsequent decision that the woman might (and sometimes will) decide to birth unattended, there seem to be three possible choices for the midwife:

1) Encourage and enable freebirth.

This is promoting of women's power to choose but with the attendant exposure of the woman to danger / risk. It is a challenge to the state's failure to provide for the woman's choice. It could be construed as an anti professionalism stance, possibly even as unprofessional. Furthermore, it is a denial of personal moral responsibility to fail to attend a woman in need.

2) Turn a blind eye and a deaf ear.

This is a simple denial of moral responsibility.

3) Discourage freebirth

This is an anti-autonomy stance. It actively colludes in diminishing women's power to choose. It exposes women then to the equally real dangers of interventionist birth. It could be construed as protectionist professionalization on the part of midwifery. It is a denial of moral responsibility to challenge the system and protect women from coercion, diminished choice and increasingly interventionist birthing practices.

Choice in place of birth and in professional birth attendant, or choosing to have none, are thus revealed to be contested areas in contemporary childbirth despite the dominant model in Ireland offering little or no choice in either. These choices exercise independent midwives because their practice places them in direct personal contact with women who contest the dominant model of maternity services and who share, at least in relation to place of birth, a common cause in this aspect of birthing autonomy. Independent midwives, if they are to be consistent with their philosophy of birthing autonomy, should at least, and from their responses do seem to, understand the logic of freebirthing.

As one of the independent midwives pointed out to me when I sent this section to them for review, there is within these choices the possibility of an active push for change rather than simple encouragement or discouragement. As she pointed out, freebirth is not currently illegal so women and midwives might push for clarity and support for women to freebirth. This, however, might well end up having the opposite effect of bringing it to public and most especially to State attention and result in reactionary forces making it illegal thus furthering professional protectionism rather than birthing autonomy.

Then of course there is also the question of illegal attendance. Just because something is illegal does not mean it is impossible. Indeed it usually indicates it is very possible but frowned upon by civil society. There are several scenarios where illegal attendance, as opposed to truly unattended freebirth, might be possible. The first is to accept that people (women) without formal training can competently attend a birthing woman. Traditional midwives the world over perform this function with various albeit unmeasured degrees of

success.⁸⁵ Even in circumstances where freebirthing, untrained attendance or negligible professional attendance pertains, ‘natural’ human birth has a reasonable ‘success’ rate. Is it possible to ascertain in whose interest is a closed professionalized system of birth such as exists now in Ireland? It certainly gives considerable power to the professions and diminishes birthing autonomy. Such a radical questioning of the status quo might seem preposterous but it belongs to the same category as questions of infringed birthing autonomy in institutional settings. This is an example of where the philosophy of birthing autonomy comes into conflict with midwifery professionalism.

There is another set of scenarios I would like to consider, and they are attendance by a midwife (or doctor) in circumstances where that attendance is illegal. It may be because the midwife (or doctor) comes from another jurisdiction, did not attain formal recognition by the registering body (for example failed examinations), or has been removed from the register. In each of these cases, the individual does not lack the skills to attend but rather the professional (and statutory) permission to attend. They are non-professionals. Refusal to allow them to legally attend birth is a professional decision; it is an expression of professional power. The professional body has the power to determine that the individual is not a professional and thus may not attend a woman in childbirth. This is presented as protection of the public from inferior or dangerous practices and practitioners. A midwife who neglects to keep up her registration or who has been struck off the register may, like any other person, choose to attend a woman in childbirth but illegally. Whether this is more or less moral than leaving her to birth unattended is, as a moral question, one I feel only the individual concerned may adjudicate upon. It falls very close to, but strictly outside the consideration of professionalism. It is however well within the remit of midwifery professionalization and claims to serve (protect) the public.

⁸⁵ Even the worst maternal and perinatal mortality estimates eg. 2000 maternal death per 100,000 ^A and 75 perinatal death per 1000 ^B mean that 98,000 women per 100,000 births and 925 babies per 1000 survive the process. (Morbidity, later child mortality and, in these examples, the privations of war aside.)

^A 2100 Sierra Leone, 1800 Afghanistan and Niger. Source WHO World statistic 2009
http://www.who.int/whosis/whostat/EN_WHS09_Table2.pdf accessed 15th Sept 2009

^B Western Africa 76 Middle Africa 75. Source WHO Neonatal and Perinatal Mortality Country, Regional and Global Estimates 2006
http://www.who.int/making_pregnancy_safer/publications/neonatal.pdf accessed 15th Sept 2009

It is interesting that if clinical indemnity insurance is made a legal requirement for professional midwifery practice, and if midwives wishing to offer home birth services cannot obtain such insurance, then that practice of attendance at home birth effectively become illegalised. This situation faces Australian midwives who have been told they may not practice without insurance (Licqurish 2009). Withdrawal of clinical indemnification by private insurance companies, as has happened in Ireland and in the UK (see chapters one and eight), leaves individual practitioners exposed to claims for negligence, malpractice and compensation. This is disincentive enough to offering home birth support and threatens women's birthing autonomy. Making unindemnified practice illegal more explicitly threatens birthing women's choice and autonomy. The profession's decision to allow, encourage or collude in State (or multi-State such as the European Union) 'regulation' of professional practice requiring indemnification thus has enormous consequences for women's birth choices and birthing autonomy. Such decisions also threaten to impinge upon midwifery practices. Professional autonomy requires professional recognition and yet certain practices, such as home birth, have become increasingly marginalised and threatened by systemic structures and decisions influenced by actuarial, corporate financial and economic global forces.

When we were discussing the consequences of indemnification withdrawal and the possibility of making home birth practice illegal myself and a midwife colleague each independently expressed the notion that if they make home birth midwifery illegal, then we would make an issue of it. 'Go on, arrest me!' (p2L1 Diary 12Dec07). It is a political issue worth fighting for.⁸⁶

In Ireland, because the HSE have given a certain degree of cover for home birth practice, paid from the public purse, they have successfully avoided demonising women, midwives and home birth. The decision has however diminished home birth choice while seeming to give it some support. Once more birthing autonomy has been both eroded and

⁸⁶ Independent midwives could become 'illegal midwives' such as described in Jennifer Block's book *Pushed* (2008) and Mary Lay's (2000) *The Rhetoric of Midwifery*. The same fate awaits Australian home birth midwives (Australian Senate Community Affairs Legislation Committee 2009).

sustained without the core issues of professionalism and professionalization being fundamentally questioned, let alone challenged.

Midwifery and in particular independent midwives live at the interface between issues of individual human autonomy and wider social forces that maintain the structures of power, patriarchy and professional self-interest in the wider population and wider society. Their political reality lives the tension between individuals' experiences and population considerations. The political tension pervades all aspects of midwifery discourse from the normativisation of science and the application of epidemiological and statistical norms to evidence based practice as generalised and unquestioned 'good'. Unconstrained relativism, and the deconstructing and destabilising discourses of postmodernism do not offer a satisfactory direction, but the grand narrative of modernism has too many anti individualistic moments. A reflective modernity seems to offer a means by which to steer a considered course into our future. This story of independent midwifery practice in Ireland is but one small story that tells of the personal dilemmas of birthing and attending birth in contemporary society. This story contests the assumptions of progress in birthing and requires that they be further examined.

A dilemma: Duty of Care

Duty of care is a concept predicated upon having a professional relationship. When a health professional agrees to provide a service to an individual client or patient, there is an obligation upon that professional then to provide a standard of service based upon the best available evidence and judged appropriate by one's peers. The 'duty' arises from the contract relationship and the 'care' is the standard of service (Dimond 2002).

In the words of one independent midwife:

'you've given your word, there's an obligation' to the mother, to be there'
(p6L15 Int 13Feb07).

In hospital the beginning of this relationship is very explicit. From the first antenatal visit the contracted professional relationship is clear. It is not usually a contract with a particular midwife, but the midwife, as employee, has a duty to care for those women within the hospital to whom she has been allocated. This includes attendance to women presenting to the hospital in emergency.

Maternity hospitals and the Health Service Executive (HSE) no longer provide a dedicated obstetric ambulance service.⁸⁷ Women in obstetric emergency have access to the same emergency ambulance service as is publicly available. Ambulance personnel, not midwives, are expected to manage emergencies of precipitous deliveries until arrival at hospital. The concept of duty of care applies then at the first point of access to the health services and can in emergency be prior to arrival to the hospital.

The independent midwife is in a different context to the hospital midwife. Simply by calling oneself, or being known as, a home birth midwife, it becomes possible for women to ask for and anticipate attendance or assistance where no such assumption might be made of hospital employed health workers. Not having a distinct place of work, but rather having made explicit a willingness to work in women's homes, perhaps creates an expectation that the midwife will attend any birth at home. Having expressed more than sympathy, perhaps even a political allegiance to home birth, an expectation to attend any and every home birth may ensue.

The independent midwives talk quite often about having or feeling a 'duty of care' not only to women with whom they have agreed to work but also to women requesting their services. The following are some examples of this belief.

'I felt a duty of care, despite she was a gravida 9 with a bad history and looked anaemic.' (p7L23 FN 21Sept08)

Comments on a woman seeking home birth with breech presentation:

'Yeah exactly and she wants to, and you go through all the problems with the breech with her and then you go through what they're going to do in the hospital with her and all the benefits of that and she ultimately turns around and says to you well I've made the decision, I want to stay at home and you say then ok then, My only question is who is the most appropriate person and the most skilled person to attend this mother and if the person who is attending this mother, has she got the skills, is it within her scope of practice and if it is that's the midwife [who should deliver] if its not she gets another midwife, if she can't get another

⁸⁷ Such a service had been available from some of the maternity hospitals when community midwives were employed to do home births within the hospital's 'district'. See Colgan (1992) for mention of the role of the community midwife in Dublin.

midwife *she can't abandon this woman anyway*. So you know that's how it all pans out.' (p32 L67 Int 05Jun07)

Without having agreed or contracted to provide a home birth service the midwife has no legal duty to care. The difficulty or dilemma for midwives is however that they do care and some do consider themselves to have a duty to care even before a verbal contract pertains. There is a desire to help and to attend women who want a home birth. This is felt whatever the woman's circumstances.

This urge to help, and belief in women's choice, can mean that midwives find themselves having said yes on a moral impulse. They find themselves in a situation where they then have a legal duty of care because they have agreed to attend. The moral impulse to help and the belief in woman's choice remains but the midwife may find her or him self attending a home birth and with a duty of care to a woman in less than ideal circumstances.

To say no, where there are no logistical, family or personal reasons to decline, is to say the professional has a right, either on a whim, or on the grounds of superior knowledge, to deny the woman's choice.

Thus there is a dilemma. Both choices have negative consequences. The former are practical and professional, the latter moral.

Other midwives feel a duty of care for those who call upon their services in emergency or without notice. One tells the story of woman who had been on a DOMINO scheme but went over her dates (EDD). She was told to go in [to hospital] but refused. She rang the midwife saying she was in labour. 'I felt ethically and professionally I must go [to her]' (p12L16 Diary 11Oct07).

Some midwives suggest they are required by law to attend women who call them in emergency but I can find no such statutory requirement. There are several pieces of legislation internationally that recognise 'Good Samaritan' actions. These do not however require that one gives aid. Such legislation attempts instead to protect professionals who come to the aid of others in emergency, from being held liable for damages arising from their intended helpful actions. Even in emergency however professionals still bear some responsibility for the quality and appropriateness of their care in those situations.

Again then there is a dilemma. Decline the moral impulse to help and there is no professional consequence. Accept the moral impulse and face a less than ideal situation with some, but not guaranteed, protection against professional liability.

The dilemma here is a side branch of the more general dilemmas inherent in balancing the autonomy of the woman and the midwife's own personal or professional autonomy. These are discussed under the sections autonomy and freebirthing and again in the dilemmas regarding the acceptance or rejection of guidelines. Here it is simply whether to accept or reject the legalistic interpretation that before a contract is entered into with the woman there is no duty of care. However, simple denial of 'duty of care' does not adequately address the feeling of 'duty to care'. Some midwives evidently believe there is a duty 'to' care even at the first contact. They feel somehow obligated and so take on cases that do not fit guidelines and contracts. Alternatively they feel that they are morally compromising themselves if they decline. There is potential for abuse of a midwife's selflessness, or for midwifery martyrdom if this tendency to take on every case is not reflected upon.

The dilemma presents itself, perhaps more usually, in emergency situations, 'will you come right now?' Again there is no contracted duty of care but perhaps a strong and immediate response, a feeling of that moral duty to care.

Whatever the impulse, once a midwife presents to attend at a birth she thereby becomes accountable and responsible; she has then a duty of care and faces all the consequences and dilemmas ordinary to midwifery practice. The impulse to care, to be with, to support pregnant and labouring women can put the midwife in a position well outside the usual constraints of guidelines and contracted care. This may be the result of an unreflective moment or may be the consequence of a very clearly articulated sense of a higher moral duty to care.

This dilemma captures the essential tension and prioritisation between commitment to women's birthing autonomy and commitment to professional norms.

A dilemma: Guidelines

Guidelines and their contestation, present independent midwives with many dilemmas in their practice. I will not immediately list the particular guidelines that are problematic but rather attempt to unpick the nature of guidelines as a dilemma for professional practice. In this section, I propose to demonstrate that the discourse on guidelines is perhaps the single biggest expression of the power of the profession which the midwives have to face. They must integrate concern for professionalism with that other major midwifery concern preservation of women's birthing autonomy.

The dilemma at its most basic is whether to accept or reject guidelines, to accept them as rules or not. Where the mother's preference, the midwife's professional clinical opinion and the guidelines coincide there is no dilemma. It is only when there is a difference of opinion about which of those three elements (mother, midwife or guideline) takes precedence, that guidelines become problematic.

I will examine rejection of guidelines first. There are two levels at which guidelines can be rejected.

Wholesale rejection of the appropriateness

Guidelines for professionals may be rejected out of hand on the basis that a woman's birthing autonomy and choice take precedence over all other considerations. Guidelines, as products of professionalization or occupational self justification, are irrelevant and inappropriate means of attempting to control women's birth choices. This is an extreme rejection of the concept of a collective profession at all. There is no appeal to professional consensus or agreement and there is no means for judging inappropriate action, dangerous or bad practice.

Reflective rejection of guidelines

Alternatively the principle that guidelines are appropriate expressions of professional knowledge or expertise is accepted. Guidelines may still however be rejected by argumentation internal to their own logic. The midwife may reject the specific guideline by contesting its development, its rationale, its evidence base, or the appropriateness of

its application to the individual. The following are some examples of midwives considering, contesting and rejecting guidelines.

“I’m 99% Ok with NICE, but many NICE⁸⁸ recommendations are not based on evidence but on expert opinion, and it’s not our opinion.’ (p1L31 FN 16Oct08)

A midwife reports that the policy within her home birth scheme is that at term (40 weeks) plus nine days the women is supposed go to the hospital for an ultrasound scan. A woman in her care has an appointment booked for day ten and the midwife says to me ‘God forbid at ten days something happens because then they’d [the hospital ? consultants ? home birth review board?] say why didn’t you ?.... and all that’ (p6L31 FN 20Nov06)

One midwife speaks about midwifery and public health nurse colleagues advising her not to go out to a woman planning a VBAC [vaginal birth after caesarean section] home birth. ‘I desperately wanted to talk to someone. I’m too old to be fighting city hall. Just because she’s at a bit of an increased risk, if she’s willing to take that risk it’s ridiculous. I feel bad as women ought to be enabled to have it at home, it’s shorter, easier, there’s one to one total support.’ (p7L5 FN 15Sept08)

A midwife tells her story of being with a woman in labour noticing meconium stained liquor and advising calling an ambulance for transfer to hospital. The woman said she would go absolutely hysterical in the ambulance and the midwife believed her, knew her well enough to predict that yes she would, so stayed with her [despite guidelines] in her home. The midwife talks of feeling ‘I’m on my own here, and I know what she’d be like’ (p4L50 FN18Sept08)

Despite experiencing a PPH (post partum haemorrhage, severe bleeding after the baby is born) some women still opt for a home birth in a subsequent pregnancy. In such cases the risks involved are openly discussed and the generally acceptable practice of recommending hospital birth is explained. However some midwives would not automatically rule out another home birth for such a mother. A second PPH would definitely rule out further HBs. One midwife cites only having encountered one client who had two PPHs. (p7L25 Int 13Feb07)

Several midwives give example of the effect of scaremongering and guidelines. One showed me guidelines for vitamin K administration with the incident report form if refused. The mother has to sign refusal. (p1L28 FN27Jul07)
Another said ‘they get to thinking that it’s [vitamin K administration] a must, which it isn’t’ (p7L22 FN 15Sept08)

⁸⁸ National Institute for [Health and] Clinical Excellence NICE, is a UK NHS body that produces guidelines for clinicians including those in maternity services

Let me focus on the principle for rejection of guidelines rather than the particular circumstances. There seem to be three main reasons for rejecting particular guidelines despite the general principle of guidelines for practice being acceptable. They are specific contestation due its the development, rejection on the grounds of the evidence, and rejection due to inappropriate application of the general to the specific circumstances.

Contestation due to development

As the first quote in this section demonstrates, midwives consider that the obstetric and institutional custom and practice dominate maternity service guidelines. This remains the case in relation to domiciliary midwifery and home birth guidelines in Ireland.⁸⁹

Risk averse and fearful thinking about birth leads to ever more restrictive guidelines that have little flexibility. Women and midwives have little say in the development of the guidelines. Even when women and midwives are involved in guideline development, midwives report that obstetric opinion or power of ‘veto’ is used to enforce restrictions (see below).

Overt privileging of hospital norms and routines in the development of guidelines for the domiciliary setting, also undermines their legitimacy. Rigid time constraints for example, have become a considerable feature of institutionalised birth, seen for example in the use of the partogram in active management of labour (O’Driscoll et al. 2003). Home birthers and home birth midwives resist standardised and rigid time limits for pregnancy and labour. They see such time constraints as a main source of unnecessary intervention and thus reject the simple transfer of hospital timing norms to domiciliary setting. In a similar vein home birth services which are restricted to certain geographical areas based upon time distance calculations (as exists for the one remaining hospital based service) are defended upon maternal or fetal safety grounds; yet many mothers using mainstream maternity services live further away and must travel larger distances in emergency, in

⁸⁹ Home birth suitability criteria or guidelines devised for the 1996 pilot schemes were derived from hospital services and on consultation with obstetricians. The guidelines recommended by the Domiciliary Birth Implementation Group (DBIG), were derived from those in the Southern area Cork and Kerry home birth scheme. Those original guidelines involved considerable input by obstetricians who demonstrated resistance to the idea of home birth and a desire to restrict its availability, rather than to find means for facilitating broad availability of a home birth service.

labour or just on suspicion of self diagnosed labour. Restrictions upon home birth choice based upon service or system needs are not suitable grounds for home birth guidelines. Furthermore when funding and indemnification of midwives is tied to guidelines, as is the case in the current memorandum of understanding between the HSE and independent midwives, this explicit expression of power is understandably resented. (This point is made clear in the next section where guideline restrictions are complied with despite disagreement.)

The Domiciliary Birth Group (DBIG) that developed the memorandum of understanding (MOU) between the HSE and the independent midwives did have independent midwives and women representatives from user groups on each of its four subgroups. The criteria for suitability for homebirth are still however quite restrictive as the group as a whole seemed unwilling to push the boundaries beyond that which had been put in place in Cork home birth scheme which was its model. Independent midwives experience in the development of guidelines is outlined further below. Other reasons for rejection of guidelines will be discussed before a broader consideration of guidelines as a characteristic of quality in professionalism and as means of professionalization which come at the end of this section.

Rejection on the grounds of the evidence

The first quote, on page 241, demonstrates midwives awareness that many guidelines are not based upon any evidence, and sometimes on contested evidence. Thus they can be rejected. Better guidelines such as the NICE guidelines now include some indication of the quality of the evidence upon which various aspects of a guideline are based.

Rejection due to inappropriate application

Even where a guideline is based upon apparently incontrovertible evidence⁹⁰ there is the possibility that the generalised application of the guideline is inappropriate in a particular case. Familiarity with the particular individual and her circumstances may encourage the midwife to reject the guideline in a particular instance. Arbitrary or conventional cut-off

⁹⁰ For example that babies born to women with diabetes have poorer birth outcomes, Penney, Mair and Pearson (2003)

points on ranges of normal such as the duration of pregnancy or labour, are cases in point, that may fail on any or all of the above three tests of appropriateness. All three grounds for rejection of a guideline characterised here as reflective, are categorically different from rejection on the grounds of the mother's decision alone. Yes the woman herself may query the appropriateness of the guideline but the midwife has not denied the principle of guidance, only the absolute unquestioned application of guideline as if it were law.

Acceptance of guidelines

As outlined above, when the mother the midwife and the guideline all agree there is no dilemma.

Midwives may argue that having some criteria for home birth and independent midwifery is a good thing (p11L45 Diary 11Oct07). This is perhaps because it at least validates home birth and autonomous midwifery practice in some circumstances; which in turn suggests that home birth is more respectable than it had been prior to the 2007 memorandum of understanding between the HSE and the independent (self employed) midwives. However in Cork, where criteria have been in place for several years (since 1996) simple statements by midwives such as 'we prefer to go by scan dates' (p16L33 FN 21Oct07) seem to indicate an uncritical or resigned acceptance of the confining structures of local practices upon midwifery and birthing autonomy.

Paradoxically, even when the midwife complies with a guideline, she may experience this as problematic. Sometimes independent midwives act in accordance with guidelines despite disagreeing with them. The following are some such examples:

Several say they strive not to be antagonistic (p1L18 FN 16Oct08), that they have been 'advised not to stretch it' (p7L37 Diary 25Apr07).

'If they have medical problems or previous C/S, I don't take them. Not that I haven't the courage, I just don't want to have to take on the whole system. I have more than enough clients. I know it's unfair to the women.' (p6L24 FN 11Jul08)

'there is an element of defensive practice, like dropping VBAC⁹¹ or anything outside the scheme guidelines, it's too great to chance it.' (p3L23 FN 18Sept08)

⁹¹ VBAC vaginal birth after caesarean section

Independent midwives express time and again their belief that if there were a problem when they stray from guidelines, they ‘would be dragged over the coals for it’ (p3L32 FN 20Nov06)

‘I was a free spirit, now there’s so much litigation and so many people being hauled over the coals’ (p7L35 FN 15Sept08)

Another says she chooses her battles carefully (p2L33 FN 11 Jun08).

To keep service

Independent midwives are torn between pushing forward the home birth agenda and protecting their compromised and vulnerable position as (almost) the sole providers of home birth in Ireland. When the midwives talk of working within guidelines or accepting them when they would rather not, the most common reason cited for accepting guidelines is that they do so for some greater perceived good. ‘Look at VBACs, it breaks our hearts but we’re all resigned to it. We are accepting a lot of crap that we wouldn’t without the scheme’ (p7L27 FN 18Sept08). They are clearly able to reflect upon the choice and its costs describing the dilemma of ‘whether we forgo that autonomy for cover and practice in a circumscribed way’ (p10L12 Diary 24Jul07). They acknowledge that they are ‘more concerned about saving their scheme’ (p3L23 Diary 05Jul07), not bringing disrepute (p2L36 Diary 12Sept07, p4L42 Diary 18Sept07), or to protect the service (p3L4 Diary 12Sept07, P8L35 FN 21Oct07).

Alternative interpretations of independent midwives’ acceptance of guidelines as if they were law, might be less altruistic than the desire for the maintenance of home birth services. These alternative readings are also derivable from the same textual sources above. It may be that the midwives more acutely fear personal retribution like being ‘dragged over the coals’. Fear for one’s professional status, arising paradoxically from the frank expression of that professional autonomy, seems to underpin the dilemmas and anxieties of the independent midwives. They fear (or anticipate) attack from their own and the obstetric professions. One midwife reports feeling that while hospitals have meetings to discuss perinatal incidents within their institutions they pay particular

attention to ‘the naughty ones’ that is, ones related to independent midwifery and home birth (p4L1 Diary 14Nov07).

What I have tried to demonstrate here is how guidelines become a collective source of dilemmas for independent midwives. There has been a degree of abstraction in this section in that the specific guidelines and the particular arguments used by the midwives to contest them have been glossed and categorised. I have outlined categories to identify the rationales and strategies offered for accepting or rejecting guidelines have been outlined.⁹² They are:

Guideline rejection categories / strategies

- 1) Wholesale rejection of the appropriateness of guidelines
- 2) Reflective rejection of guidelines
 - a) Contestation on the grounds of development
 - b) Rejection on the grounds of the evidence
 - c) Rejection on the grounds of inappropriate application

Guideline compliance categories / strategies

- 1) For the greater good
(Explicit fear for home birth option / service,
Implicit fear of punishment/ professional opprobrium)

So it seems that happy coincidence of alignment between the mother’s and the midwife’s opinion or judgement and the guideline, the product of official professional discourse, is unproblematic. Misalignment causes a dilemma for the midwife either in rejection of the guideline or in compliance.

Again, as with previous dilemmas, either decision to reject or comply, is fraught with further unpleasant consequences. Compliance with restrictive guidelines diminishes

⁹² **Negotiation:** Of course guidelines are not always simply accepted or rejected. Very often the grounds for contestation are discussed amongst midwives. The independent midwives tell of many hospital midwives, GPs or consultant obstetricians who have been very amenable to and supportive of home birth. They can be supportive, as well as obstructive, as was mentioned in the first chapters on relationships. In the context of guidelines however I would like to note that negotiation is a strategy for dealing with guidelines and their ‘enforcement’. Data supporting negotiation is included in the appendix under communication and liaison (chapter five) and under this section, guidelines.

women's choice. It diminishes birthing autonomy. Arguments that compliance maintains some sort of service are offered, but compliance is obviously a source of frustration for the midwives. There is a suggestion too that compliance is a way of avoiding the negative consequences of rejecting guidelines. The negative consequences of rejecting the guidelines on one's own judgement have been suggested in the phrase 'being dragged over the coals'.

A dilemma: Transfer to hospital care

Decisions whether or not to transfer from midwife care at home, to obstetric care in hospital, are very frequently cited by independent midwives as significant and often highly stressful aspects of their work.

Following a story of slow progress in second stage with early decelerations where she decided to transfer to hospital, the midwife says that is one of the most stressful things to have to do. 'Having to make that decision, but also the time afterwards where you question yourself – should I have transferred at all ? Did I too soon, or too late ? (p1L34 FN 19Feb08)

Suggesting transfer to hospital care when the woman has hoped for a home birth is stressful but often not a dilemma for the midwife. The midwife's own assessment of the situation may conclude that home is no longer a suitable place for the birth and the woman may agree and / or trust that the midwife is making that judgement with the woman's own interest at heart.

Look I said I'd like you to just quickly listen in before she goes back over onto her back because this FH [fetal heart] has been perfect on transfer and I want to make sure its perfect before I leave. But the policy was, you go in and bring them to the labour ward door and then you have to go. That's policy and I was happy enough with that 'cos in fairness if you transfer you transfer for a reason and the staff are there to do their bit and I'm only in the way and I don't feel like some midwives would feel that you should be in there and have these honorary contracts to deliver the women. I don't feel like that at all. If I transfer, I'm transferring in for them to take over because that's problematic, full stop. (p7L5 Int 17Aug06)

'It's not home birth at all costs'. 'If she says 'I want to go to the hospital', that's fine with me' (p7L4 Int 13Feb07).

‘When I make a decision that this labour has stalled or not progressing in a normal way and the woman is exhausted or whatever it is, I make a clear decision and I’ve no ambiguity in my mind that a transfer is a transfer for a good reason.’
(p17L16 Int 11Jul08)

Clinical decision making can be a stressor, but when decisions are made more difficult by systemic structures beyond the midwife’s immediate control, or by protocols which are contrary to her philosophical stance, clinical decisions can become dilemmas. Guidelines pertain to monitoring and transfer as much as they do to setting suitability criteria for home birth in the first instance.

There are several ways in which a transfer decision may become or present as a dilemma for the mother and the midwife. They will be highlighted in this section.

Birth autonomy even at transfer

The mother (and midwife) has obviously planned and hoped for a home birth but sometimes circumstances make hospital birth more appropriate. The hoped for home birth can seem like something lost. A member of the Home Birth Association (HBA) suggests that even when transfer to hospital has occurred that it is important to value the decision and the plan for home birth. She suggests that for mothers it is important to counter any sense of failure and to acknowledge they still had a planned home birth. The decision to transfer to hospital can be made by the mother or by the midwife but in careful consultation with the mother.

‘But even in deciding to transfer, they were making the decisions all the way’
(p10L41 FN 21Oct07)

[the midwife] is at pains not to talk the woman into home birth – to reiterate freedom and choice to transfer - a tricky balance between optimism and pragmatism. (p27L47 FN 20Nov06)

Tends to create thinking space early for parents if she has any doubts – sometimes this, could be, might need to be transferred ..., while watching, waiting and assessing the need / condition – this sowing the seed seems to be a theme in several stories. (p29L19 FN 20Nov06)

Sometime however the signalling may not be picked up.

A midwife tells story of how she had to get her woman to hospital due to very slow progress but that somehow woman and her partner didn't get the urgency message. The midwife felt she had been signalling this slow progress to them but that they didn't read it. Even an hour after clear (according to the midwife) planning – if you're not pushing in one hour - they seem shocked by transfer. The midwife tells it was deep transverse arrest delivered eventually after vacuum rotation, and that she blames herself for not being clearer in her language to them about slow progress. 'I didn't make it explicit enough' (p4L12 Diary 02Oct07)

Loss of relationship

Apart from the sense of failure and the sense after the fact that the decision may have been made too soon (as in the first quote in this section), the relationship between the mother and the midwife is broken when transfer occurs (as in the second quote in this section). Other midwives report that this is problematic for them.

'what was really important to me was being able if you looked after a woman say for 12 or 24 hours whatever at home and then to be able to go into the hospital as an advocate and support that woman till the baby was in her arms and support her with the first feed etc.' (p4L4 Int 09Dec08)

Structural obstacles to independent midwives carrying on in their relationship with women after transfer to hospital are a significant stressor for them and for the mothers. It is a major disincentive to transferring to hospital as the woman has no prior trusting relationship with them in what is a very vulnerable time for her. Some hospitals do facilitate the midwife staying with the mother on transfer – either as the primary care giver or as a continuous support person only. Several midwives describe the withdrawal of this privilege (for whatever reason) as being a significant hardship in their practice.

Pre-transfer history ignored

Another aspect that midwives report being problematic about transfer is that often what has happened at home is effectively ignored by the hospital as if it never happened or was irrelevant.

'I would write a letter to the hospital explaining the situation because the hospitals never take into consideration what has happened before at home, once they have a letter then at least I've done what I can' (p7L19 FN 30Nov06)

The midwife had been telling the woman ‘you’re nearly there’ for 6 hours, then on transfer in, so did the hospital midwife, and then the hospital consultant; What she really had wanted on transfer was an epidural. (p8L12 FN 20Nov06)

This disjunction, this lack of continuity is not only the lack of the same birth attendant, as above, but also a lack of continuity or smooth progression of care.

Clearing up their mess

The most problematic aspect of having to transfer is the reaction of those in the hospital to the transfer. Here one midwife describes the strain and contrasts it with previous good experiences transferring in the UK:

In a difficult context most commonly, you know transferring in, to me you’re doing the right thing if you’re transferring in labour you’re obviously doing the right thing, You’re staving off a potentially dangerous situation but the staff inside see it differently. **They see it as mopping up your mess really** and it’s because, it’s the cultural difference, again in England if you transferred a woman in they were just delighted to see you. And they just, you know you just were part of the system. You could stay with the woman in labour, here you don’t. (p14L43 Int 17Aug06)

Talking of professional isolation she says ‘even your colleagues (other midwives) look at you, intimidate you, make you look small’ (on transfer of women into hospital) ‘there’s only so much of that you can take’ (p8L24 Int 13Feb07)

‘as practitioners we are so isolated. If you do have to transfer in, you have to be able to defend your practice. If something did happen you always have to defend your good practice.’ (p5L33 FN 11Jul08)

When contacting hospital for advice or transfer several midwives suggest:

getting or having a relationship with the registrars in the maternity hospital. It took me some time to unpick why registrars, but it seems in her experience they’re the ones who are daily making rapid serious decisions and unlike consultants or labour ward sisters are much less likely to spend valuable time asking why the independent midwife is ringing, or judging the independent midwife. (p45 L15 Diary 18Apr06)

‘the registrars they are usually keen to get the problem solved rather than score points – compared to the midwives or the obstetricians’ (p34L6 FN 20Nov06)

hospital midwives finding fault and blaming rather than getting to the point and helping solve the presenting problem. (p4L4 Diary 13Oct06)

As outlined in the relationships section, many midwives find many obstetricians and many midwives supportive and helpful on transfer and in everyday interactions. This support is not universal however as the examples in this section demonstrate.

The issue of transfer to hospital has elements of the dilemmas already discussed as inherent in the use or application of guidelines. On top of those dilemmas however come layers of difficulty arising from disappointment for the mother and midwife from loss of the hoped for home birth, the loss of the relationship that arises from not being ‘allowed’ to stay and continue care in the hospital. Furthermore experience and anticipation of a sense that the hospital staff may view transfer in as a criticism of home birth and a clearing up of the independent midwife’s mess makes transfer problematic. Both transferring and not transferring have negative sequelae and so this too is a dilemma for midwives.

A dilemma: The status of the fetus in Ireland^{93 94}

It is perhaps on this issue more than anywhere else in the ethnography that I have had to reflect on my own position. I believe that a woman should have the right to control her reproductive functions. That extends from her freedom to choose, or choose not to have, sexual partners and long term partners. Women should be able to control their fertility which includes access to safe and affordable contraception. While avoidance of conception is preferable to abortion, safe and affordable first term abortion is a choice women should be freely able to make given the social and structural constraints placed on women regarding pregnancy, childbirth and parenting. Later abortion and women’s rights and freedoms during pregnancy especially after viability are more hotly contested, but my own position is that women are best placed to make decisions about their bodies and

⁹³ Article 40.3.3 of the Irish constitution, following the eighth amendment in 1983, states: ‘The State acknowledges the right to life of the unborn and, with due regard to the equal right to life of the mother, guarantees in its laws to respect, as far as is practicable, by its laws to defend and vindicate that right’.

⁹⁴ The contestation between mother and fetus appears in countries other than Ireland for example in the USA see Ginsburg (1989). But also the whole status of the fetus appears in Lorna Weir’s work (2006) on the biopolitics of the perinatal period.

their babies. Real support for all costs and consequences of all alternative decisions in late pregnancy is necessary for truly autonomous and moral decision making. I believe women do not take these decisions lightly or without careful consideration of the consequences, both for the baby and for themselves. The final arbiter about the life (or death) of the baby within her should be the mother. That a pregnant woman should have her human rights even contestable by the ascription of rights to the baby within her, is unacceptable. The asymmetry of the human species divided between impregnating male and impregnable female is a biological reality. The social structures that serve that human reality must not perforce diminish the dignity of one half of the species by privileging their (potential) offspring. Actual human dignity precedes and is rightly privileged over potentiality. The threat that that potentially poses to the unborn child can be best avoided by privileging women's status and control in all areas of their life, not by diminishing it in one.

I therefore have some difficulty with the Irish constitution's express concern for the rights of the unborn child. I have difficulty with the unavailability of safe free abortion in Ireland and the export of our abortion 'problem' to the UK and elsewhere. I have a problem too with any diminution of the rights and freedoms of the pregnant woman, either for her own good, or for the good of her baby. Any construction of pregnancy or labour as undermining of female competence or autonomy is, in my view, dangerous. To argue that hormonal variation in the menstrual cycle or in pregnancy might diminish female competence or agency is dangerous. Similarly, to argue that the 'pain' of childbirth might make one agentially incompetent is dangerous. Such argumentation is dangerous because it allows the power of (self) determination to be placed other than with the woman herself.

I felt sure that independent midwives in Ireland would, like me, have something to say about the legal relationship of the mother to the fetus within her. They did not. They had plenty to say about the relationship between the mother and the baby, about them getting to know each other, even about the midwife getting to know the baby and the baby having a spiritual presence while in the womb. The midwives never presented the needs

of the mother and the baby as in opposition. The mother obviously had the best interests of the baby at heart, even when the mother smoked for instance, the view taken was that in the context of that woman's life, the cigarettes were a means for maintaining maternal psychosocial health and that was overall better for the baby than otherwise. Not every midwife would accept that position, as has been mentioned, some for example will not attend mothers who will not breast feed. Nonetheless, the principle that the mother and the baby are a whole and that the midwife's relationship with the mother serves the two, is the abiding message. The mother is at least, if not more concerned than the midwife for fetal wellbeing. The mother and the baby are not in opposition, the status of the fetus in Ireland might theoretically put them in opposition but for independent midwives it does not. There is for them no perceived or expressed dilemma in their immediate practice and relationship with women. Independent midwives views on abortion are not within the purview of this ethnography.

The issue of the rights of the fetus as contesting, or potentially contesting the rights of the mother regarding her birthing choices and her bodily integrity does however remain. Deirdre Daly (2007:96) has demonstrated that the rights of the fetus certainly have potential for being used in case law or judicial review in several aspects of maternity care.

A dilemma: Politics and Reputation

The independent midwife must choose whether it is better to be a birth activist or endeavour to remain quietly under the radar in one's day to day midwifery practice despite the MOU and other constraining factors. Again, as with the issue of the status of the fetus, this is a dilemma that I brought with me from the outset of the study and which was and remains a concern in my own practice.

I recorded the following in my field notes:

I spoke of my fear that this study might make independent midwives more vulnerable.

The midwife I was speaking with said that she also would be scared that this study could reveal all the weaknesses and quandaries of independent midwifery, to the point of ridicule. That there would be no hope for autonomy and advocacy for independent midwifery or for women – 'I couldn't bear that' If it showed that

independent midwifery was too difficult, that there was no insurance, that midwives made stupid decisions or that they went beyond their scope of practice. She compares this pressure against, or vulnerability of, independent midwifery and home birth, to the pressures of materialism. It concerns her that anyone reading [this study] might / could / would read it in black and white and see independent midwifery as an avenue not to pursue. However she feels that if and when a student meets an independent midwife, or sees midwifery practice in the community, they are inspired by it; More so than if they just read about it. It's not the same reading it. (p5L23 FN 21Oct07)

Midwives' concern for their reputation is demonstrated in the following story told to me by the midwife involved:

A woman had been labouring at home for 3 days, she had a prolonged latent phase, and she was exhausted. So the midwife wrote a letter to the hospital explaining the situation 'because the hospitals never take into consideration what has happened before at home' – 'once they have a letter, then at least I've done what I can.'

The woman was put into an antenatal ward as the labour ward is busy; she was left for 28 more hours. She was on and off phone to the midwife who advised the mother to really make an issue of wanting / needing to be induced. The woman then had induction of labour where artificial rupture of membranes showed some meconium in the liquor. At delivery the baby needed suctioning and was transferred to the neonatal intensive care unit (NICU). The father described the baby's condition as 'critical' to the midwife and the next thing she heard was that the baby had been transferred to Great Ormond Street Hospital in London for special lung bypass ventilation on one of only two such machines. There is none in Ireland. The condition was very serious but the baby did well with no long term respiratory or developmental problems.

What annoyed the woman and the midwife however is that everyone in the hospital maternity services described the case and the baby as 'the home birth with meconium aspiration'; sending the negative message and associating the aspiration with home birth. The midwife says this is very one sided. The woman felt it was only her independent midwife that had treated her with any respect or listened to her, not the hospital. Pregnant with the next baby, the woman chose to have DOMINO care. When transferring in to hospital the receiving midwife was asked if she knew the history. She said 'yes, the meconium after home birth'. Again the mother and midwife find this very frustrating. 'That's exactly why I wanted to be there for the transfer. I knew they'd say that and I wanted to counter that, to provide balance with the whole real story.' (p7L19 FN 30Nov06)

Other than their communication and liaison with women and with their professional colleagues (which are described most fully in chapter four and the dilemmas associated with guidelines and transfer), midwives can choose either to engage quite actively in the politics of home birth and midwifery or to be quiet on these subjects only speaking as

needs must and personally to those with whom they come in contact. I have characterised these two approaches as ‘fight the good fight’ and ‘keep your head down’. There are of course negative consequences of both these approaches and I will outline what they are.

Before I do however I would like to speak autobiographically for a moment again. I am a man in my forties who grew up in Northern Ireland during what we euphemistically called ‘the Troubles’. My parents were politically active and condemned violence and the injustices they saw. My strategy for social survival (I never really perceived that my life was in jeopardy) was however definitely in the ‘keep you head down’ camp. I declined to talk of politics and certainly did not engage in politics seeing it as sectarian and divisive. I have found that since I have become an independent midwife that much of my talk and activities outside of direct contact with mothers has been political in nature. I have been engaged with other independent midwives as part of this study but also in efforts to get home birth and independent midwifery onto the public and political agenda. While I have been a midwife and a midwife teacher for some years, it was not until I took the first steps towards independent practice that I discovered the obstacles in the way and the frankly antagonistic attitudes of some to home birth. It seems, to me at least, that I have to be political as home birth choice has now become personal.

‘Fight the good fight’⁹⁵

The potential benefits of political activism in relation to home birth choice and independent midwifery is that they may bring increased recognition, tolerance and perhaps even support and expansion of the service. Mothers and midwives can act as allies in trying to bring the home birth agenda to the fore. There is also a natural alliance between independent midwives and other community service and between midwives in the hospital setting who also want to support normality in birth.

The potential losses however are that by making noise we might attract not support but resistance from those who have ‘tolerated’ a certain unorthodoxy but when the issue is brought to their door, they might choose to range their resources to further restrict choice

⁹⁵ Examples from the data appear in appendix one.

and practices or even to wipe out home birth and autonomous midwifery entirely. I am not of the view that there is an active conspiracy against home birth and independent midwifery as might be construed from the talk of the midwife in chapter four, section two pages 127 -140, but there is the possibility that by being visible one becomes a target.

‘Keep your head down’⁹⁶

The alternative is to avoid anything overtly political and just quietly continue attending women who want home births and hoping that by staying under the radar that some women will get some or most of what they want. The argument is there is only so much anyone can do, that activism is time consuming and frustrating and can lead to burn out. The personal is political and the personal contact between mother and midwife, the quiet word of mouth between women seeking an alternative will keep the flame alight until there is an impetus from the women’s movement, or in wider society as a whole, to take the issue forward in a groundswell as happened in New Zealand in the 1990’s (Papps and Olssen 1997).

The danger of this approach is however that the flame may flicker and die. With very few home births and few community midwives, student midwives get no exposure to domiciliary care and so lack the experience and confidence to do it themselves. Even with the most careful selection and transfer to hospital some poor outcomes do occur and the lone midwife faces the responsibility and opprobrium alone. Many of the midwives have spoken about the risk of burnout in an unsupported model of independent midwifery (see chapter four section three).

Compromise

Unlike so many of the other dilemmas midwives face, there is the possibility for compromise or balance between these two approaches.

Independent midwives have made their voices heard and represented their views in various fora, as outlined in chapter four. The memorandum of understanding between the HSE and the independent midwives is a case in point where gains were made when home birth looked most under threat. As pointed out in this chapter in the dilemma on

⁹⁶ Examples from the data appear in appendix one

guidelines however, compromise can lead to loss of ground as was seen in the removal of VBAC from the criteria for suitable for home birth.

It seems however that there is a continual undermining of women's birthing autonomy both in hospital (which is beyond the remit of this thesis) and in the community. Right from the start of the twentieth century, when midwifery was first recognized, there was a loss of choice to women and a diminishing of their birthing autonomy. Local wise women were very effectively forbidden from birth attendance, and the process of the professionalization of birth gained increasing momentum. The memorandum of understanding, with its attraction to independent midwives of indemnification for their practice has, in effect, further diminished women's choice and birthing autonomy. Where midwives had been happy to attend women with breech presenting babies, to do VBACs and to accept women otherwise outside guidelines, there is the added 'threat' to independent midwives that such practices are now unindemnified. Neither fighting the good fight, keeping one's head down, nor even compromise, seem able to halt this erosion of individual self-determination in the risk society and in the global market economy. It is however the place of studies such as this to at least describe or document this erosion of the human condition. Through such documentation and recognition of the protest individuals (women and midwives) are making to the loss of women's birthing autonomy, a model for resistance is seen in their praxis and might form the kernel for more determined and popular reversals of systemic patterns of oppression.

The Community Midwives Association (CMA) which, as a new professional body set up by independent midwives (mentioned in chapter four), might act as a conduit for political activity and as a support and voice for all midwives including those who would themselves prefer a more low key approach.

Summary

This examination of midwifery dilemmas speaks of the complex nature of independent practice. These dilemmas tell of the contested and the contingent nature of home birth practice in Ireland. The midwives' experience is a lived example of an alternative philosophy of birth to the orthodoxy of hospitalisation. There is a counter discourse on birth to that which exists in mainstream Irish maternity services. Their rhetoric highlights certain flaws and inconsistencies within the dominant system and their practice draws

upon them a counter critique. They feel vulnerable to judgement based upon values drawn from the flawed but dominant system. Professional orthodoxy in the determination and management of risk for example, threatens to diminish their professional autonomy. Autonomous midwifery practice in Ireland is significantly undermined by lack of professional support and supervision. Midwifery professionalism in Ireland is defined by its context. Within the broader professionalizing project, the occupations of obstetrics and midwifery contest the scope of their practice with the delineation of normal and abnormal as the major jurisdictional boundary (see chapter five). This delineation is still contested, with obstetrics ever encroaching into the normal. Independent midwives practicing outside the dominant and dominating hospital setting feel the brunt of professionalizing discourses, both from obstetrics and from within their own profession.

Chapter Nine Insurance

The issue of insurance is a very real topic of concern for independent midwives working in contemporary Ireland. There are two main, but very different concerns. One is with the concept of health insurance as a means of procuring health care and for funding health care nationally. The other concern is the indemnification for professional practice, the mechanisms for procuring it, the consequences of not obtaining it, and the meaning of the expectation that professional practice can or should be indemnified.

Before considering how these two very different issues impinge upon independent midwifery practice, I wish to discuss the development of the concept of insurance. The concept has links to several other concepts that go the heart of this critical analysis of contemporary midwifery practice.

Possessive individualism and a contract or market society

Macpherson (1962) describes the writings of seventeenth century philosophers Hobbes and Locke as political theories of possessive individualism. Macpherson demonstrates that the philosophical principle underlying their concept of personhood was as self possession or 'property in one's own person'. This concept of self-possession, extrapolated to one's other possessions and to competition for resources and power, leads ultimately to (propertied male) franchise and the political system. A political system is needed to stabilise contractual relations between acquisitive individuals. Macpherson understands Hobbes and Locke to view the political system as a means of protecting property and regulating the contract relationship. Macpherson also identifies possessive individualism in market society as underpinning much of the difficulty in contemporary global capitalism. This is not least because the desire for power in ever increasing acquisition cannot but lead to inequality. Furthermore the political system derived to protect property will not (does not have the 'will' to) rectify inequality.

Insurance and Compensation for Loss

The concept of insurance fits well into all this concern for property and the contract relationship. Insurance is the act, system, or business of providing financial protection

against specified contingencies such as death, loss or damage (Collins Dictionary 2000). The concept of insurance is inextricably tied up with the concept of risk (Ewald 1991). Mathematical or actuarial calculation of frequencies and probabilities of loss, on the same principles as betting or gambling, allowed those with property 'at risk' to spread the cost of loss between many. It was in the days of colonial maritime conquest that insurance came into being. By each ship owner paying money to a third party, that 'insurer' covered the loss to any one individual if theirs was the ship in the fleet that was sunk or lost to piracy. Those with financial capital found they could make substantial amounts of money from providing insurance, effectively betting on the difference between premiums paid in and compensation paid out. Like any bookmakers or casino, the calculation is to bring profit to the financial institution, and the bets are 'loaded' for the 'house'.

The poor are not served

The poor are not served by a political system devised for the protection of property; Nor are they served by the concept of insurance. Individuals who have property or means of making money can insure their assets. There is a problem however, for those without sufficient assets to be able to afford insurance, and that is that the poor bear the additional burden of any loss of their already meagre assets entirely on their own. Insurance then as a mechanism for the protection of property is very much part of contemporary contract society or the market economy. It perpetuates and even heightens what is already an iniquitous system. Those that have resources may acquire more, but those without and able to contract out only their (body's) labour effectively become wage slaves.⁹⁷ Thus insurance is significant in every aspect of the life of all citizens. Its lack bears especially on the poor and relatively poor. The ramifications of insurance as part of this contract society are particularly relevant, in this thesis, to provision and access to health services.

⁹⁷ See Zygmunt Bauman (2004) for a critique of contemporary global capitalism and its consequences within what we call modernity.

Insurance as a means of paying for health care

Insurance for financial loss of goods was gradually extended to loss of life and limb, and by further extension, eventually has become a means by which health services can be significantly if not exclusively funded by private health insurance rather than directly by the government through taxation.⁹⁸ The Irish State treads a balance between a publicly-funded health model and a privately-funded health model. A government with pretensions to respond to the welfare of all its citizens cannot entirely abdicate their responsibility to those who cannot buy in to private health model. Maev-Ann Wren (2003) critiques the effects of this dual model approach in Ireland, highlighting that it undermines public services and fails the poor and those without health insurance.

A public maternity service

As was outlined in the introductory chapter, Ireland has only recently provided a wholly public maternity service to all. From the 1950's to the 1990's free maternity services were means-tested and everyone else paid towards her maternity care through private and semi private attendance by obstetricians. Midwives and other hospital employees were public employees, obstetricians (and other consultants) had, and still have, a part-public part-private contract. (This is a situation heavily critiqued by Wren (2003) the reversal of which by the current minister for Health Mary Harney has met with apparently insurmountable resistance from the medical and consultant bodies.)

By virtue of having no contract of employment with the HSE, independent midwives are private contractors. The HSE, from September 2008 and as part of the MOU, now pay midwives 2500 euros (less tax) for antenatal, intranatal and postnatal care, consisting of eleven visits and attendance at the birth, plus travel expenses up to 80 kilometres for seven of those visits. On the issue of whether and how much independent midwives charge for their services, there is great divergence amongst the independent midwives. Some feel that theirs is a service that should be freely and publicly available and so take no more than the fees payable (and previously the grant payable to the mother). Others feel that theirs is a high quality, individualised and convenient service and, as the HSE

⁹⁸ See Mishra (1981), Allott and Robb (1998) and Edwards and Glover (2001), for considerations of the welfare state.

payment makes no allowance for being on call or other aspects of care beyond eleven 'visits', they charge significantly more. Some midwives take into consideration the HSE schedule of payments and charge accordingly for services over and above those itemised. There is therefore the potential for significant inequity between the cost of a home birth to a mother depending on the midwife she is fortunate enough to secure to attend her.

Independent midwifery and home birth: public and / or private funding

That midwives sometimes have great difficulty charging for their services or putting a fair price on their skills, knowledge, services and time has been documented elsewhere (Van Der Kooy 1994, Warren 1994 and Hobbs 1997).

This issue of timing of payment was responded to in a variety of ways by the independent midwives with some charging up front (their explanation was that it avoided complications later), some waiting until all is over, (and their occasional story of not being paid or having to chase up payment) and some (particularly those in the Cork home birth scheme) paid by arrangement with the HSE. The issue however of where the money should come from remains an aspect of independent practice on which there is no consensus.

The mixed public and private nature of birth in Ireland has been outlined in the opening chapter situating home birth and midwifery in contemporary Ireland. Some midwives express a commitment to public and free at the point of delivery maternity services. Others are very clearly selling their services privately. At the start of this ethnography, the inconsistency of the availability of home birth and variations in payment (or non-payment) of a home birth grant encouraged private payment for independent midwifery services. Thus the question of whether home birth should be a free public service or a private one went unasked. The memorandum of understanding (MOU) between independent midwives and the HSE secured clinical indemnity insurance for independent midwives in 2007. It is unclear however whether either the HSE, or the independent midwives, consider the current payment to be a fair and complete payment for the totality of home birth services. The independent midwives usually visit the mothers more than the eleven visits indicated by the MOU. As part of the MOU, they only get travel allowances for seven of those, and travel is limited to a total of 80 miles per visit. It is

possible they travel further than this and so it seems that the grant does not cover total care. As was also mentioned in the introduction, very many women seeking home birth have private health insurance and some companies will pay out up to 3500 euros for home birth services. The feeling amongst the women I have attended is that they get little enough from their contributions to health insurance and are only too happy to claim for their home birth. Some midwives do not ask for more than is available through the public grant. I have however accepted health insurance payments and do not decline women who do not have private health insurance. This is despite my contention that home birth should be free at the point of delivery. I feel the home birth grant should but does not cover all costs of the service including on call payments. Potential for double payment from public and private sources has not been addressed and is fudged in my acceptance of the MOU primarily for its clinical indemnity cover.

Clinical Indemnity Insurance

During the course of my fieldwork for this ethnography the Irish government, or at least its civil servants in the delivery of its policies, had to decide whether or not to indemnify the home birth practices of the small number of midwives who provided that service and who until that point had been indemnified through their trade union (The Irish Nurses Organisation INO). The trade union's insurance company advised them that home birth practice was no longer effectively insurable. In 1994 in the UK when the Royal College of Midwives (RCM) made the same decision and midwives became uninsured, the number of home birth midwives plummeted (Mc Hugh 2009). In the UK however, the integration of community midwifery into the National Health Service was so well established that a variety of models of state maternity service were available, and home birth, while a minority activity, was not entirely dependent upon independent practitioners. Ireland was not in the same position. Most of the approximately 300 (less than 0.5% ESRI 2008) home births per year were supported by independent self-employed midwives. A midwife unwilling to practice without insurance would be unable to provide home birth. The threatened withdrawal of insurance for independent midwives meant then that home birth itself was threatened. Choice of home birth was effectively being removed from the women of Ireland.

The independent midwives protested the removal of insurance by the INO describing the consequences for women's choice without it. The INO organised a meeting with the HSE and in particular with the state claims agency which had been set up in 2001 and administers the clinical indemnity scheme for state employed health professionals and institutions. It was unclear whether the State Claims Agency (SCA) Clinical Indemnity Scheme (CIS) would be applied to independent midwives as it explicitly excludes general practitioners as private entities rather than state employees. Letters from the INO and from individual independent midwives appealed to the Minister for Health Mary Harney to resolve the issue.

The following extracts, from one interview containing a long sequence on insurance, capture some of the issues and arguments about indemnification for home birth practice.⁹⁹

Within the interview three distinct themes arose: the first was the idea of being sued for one's practice with the potential loss of one's assets to pay compensation.

'It means that I could be sued for more than I, it could mean that everything I've worked for could be in jeopardy if I was personally sued. My home and my, well basically my home would be the main thing,'

'I would be very reluctant to practice without insurance in Ireland.'

'I might have a few years ago. But no, I wouldn't be prepared to lose my home over it. I definitely wouldn't. I wouldn't, I would be very passionate about midwifery and doing what I'm doing but I wouldn't be prepared to, certainly I wouldn't be prepared to lose my reputation, my home.'

'something might go wrong which you couldn't prevent but at the same time it doesn't mean that people wouldn't take you to court.'

'You could end up in a court with either the woman or the partner or husband would take you there but it could be your own professional body or a doctor or someone who perceived the fact that you are not doing the standard. That could happen anyway but at least you'd be protected with insurance,'

⁹⁹ All these extracts come from a single interview carried out in July 2008. A more complete extract is included in the appendices. Other midwives' views on the subject also appear in the same appendix.

‘And its more I think a history in Ireland of all this litigation as well, maybe not just Ireland but its more than it is now, it was in the past more likely that people would take that line, would take it into court to get compensation.’

A compensation culture then, seems to be a threat, and makes the midwife feel vulnerable. She feels vulnerable to losing her personal goods and particularly her family home. (Whether a court would ever decide on such a transfer of assets as part of a compensation claim remains moot, but the midwife feels that vulnerability.) Insurance does ‘protect’ from the financial implications of compensation arising from accident, malpractice or negligence, but it does not prevent the possibility of facing legal or statutory (professional body) investigation and censure. That remains a significant cause of concern, and can be seen in the mention of ‘your own professional body or a doctor’. This awareness of professional surveillance and expression of professional power has become closely enmeshed in this midwife’s discourse (and others’), possibly because of the similarity in the adversarial nature of legal representation at both criminal and statutory professional fitness to practice hearings.

The second major theme was that her practice would not be changed whether with or without insurance.

‘I would at this stage I’ve a lot of experience of birth, a lot of good experiences’

‘it wouldn’t be so much my reputation because I feel very strong that I wouldn’t ever do anything, do substandard care or put any mother or babies lives at risk or do things that were jeopardising their care, I don’t think I would do it.’

‘I would practice in the way that I’m practicing now. I wouldn’t do anything that wasn’t correct procedure in my view So it wouldn’t be that different, but I wouldn’t change my practice, having the insurance or not having it wouldn’t change my practice one bit I don’t think. I wouldn’t see it at all related to my practice, I would see it as related to some event that I couldn’t have done anything different but I know how people’s perceptions might be different.’

‘I don’t see it as always that I practice in a substandard way if someone takes me to court. But having the insurance would not change my practice.’

‘My practice wouldn’t change no, no.’

It seems therefore that despite the financial threat and professional surveillance suggested in the first theme, they do not impinge upon her personal estimation of quality care and professional standards of practice. Her experience and her reputation are something she is proud of and sustains without the necessity of external forces.

The third theme is that, despite insurance having no effect on how she perceives she practices, clinical indemnity insurance has become to be expected as part of being professional.

Q What would the removal of the insurance mean?

A It means also for the women that this service is almost not legitimate, where they are having all these problems. It is still very much a service that is covert and it seems like that to us as well. At least that's the feeling that this is somehow or other not such a legitimate service that we are offering because of all this, we are more at risk than we know ourselves.

It's something about being a professional as well to me. That we have, that a professional, we are seen as having cover, to have insurance cover.

Q Yeah who is saying that? Where does that come from?

A Its coming from today's world I think, modern world that it seems to be part and parcel of our way of living now.

It seems to be part of being a professional to have insurance cover. Its part of people's way of working now and it seems, I don't know who's saying it but its the way that we are set up as a professional group, medical, midwifery, lawyers and accountants all those people that we would have as a comparative would have insurance cover and we see ourselves as being that type of professional as well.

Q And you've identified something about reputation of the profession, if it can't be insured is it reputable?

A Yes, yeah is it? A lot of the women have said to me [when] I said I wouldn't practice without insurance and they said no I wouldn't expect you to. I said I see it as part of being professional nowadays, it was different years ago. But I do see it as part of being professional.

Q So somehow money and insurance has got tied into what professional is.

A It has yes, definitely it has.

Yes, yeah well I think its like in the old days there would be bartering in giving the midwife things that would sustain her life, you know, food and all that kind of thing. But it's just an exchange, it's a commodity, money is a commodity and its part of our lives.

This theme captures the fact that insurance has become so commonplace, so embedded within our society that it goes unquestioned.

This midwife then has noted the main features of clinical indemnity insurance for independent midwives:

- 1) Being sued for one's practice may mean the loss of one's assets to pay compensation.
- 2) Clinical indemnity insurance does not actually improve practice.
- 3) Yet having clinical indemnity insurance has become an expected part of being professional.

Midwifery indemnification: a dilemma

Indemnification then is another aspect of independent midwifery practice that proves something of a dilemma. The first decision to make is whether to practice without insurance; this decision itself involves a dilemma. This particular midwife would not practice without insurance. The consequence of that decision is that women would then have even less choice about place of birth. Furthermore, as the midwife suggests, hospital practice in Ireland is less autonomous than in other settings or in other countries. The decision not to practice without insurance then also has negative consequences for the midwife; it means practicing less autonomously or not at all.

The second choice, to practice without insurance, also proves to be a dilemma. Midwives in other countries, for example the UK (Mc Hugh 2009) and the United States (Lay 2000, Block 2008), practice midwifery at home without clinical indemnity insurance. Some independent midwives in Ireland may also be willing to do so (p4L31 FN 16Oct08). Midwives in Australia are very recently facing the consequences of having unindemnified practice declared illegal in their country (Australian Senate Committee 2009, Licqurish 2009). The negative consequences of this choice however, are also made very clear in the excerpts above. It is not only that it brings a sense of threat to her home and reputation should she face some legal case, it seems that working without insurance, in itself, damages the reputation of the midwife, suggesting that unindemnified practice is

unprofessional. The midwife mentions home birth as being ‘on the fringes’ and lacking legitimacy. This choice although it has its benefits, in that women still can avail of the services of a trained attendant, also then has negative consequences; such is the nature of the midwives’ dilemma in relation to clinical indemnity insurance.

Insurance as a social and moral imperative in a contract society

So pervasive is the awareness of risk in contemporary society, that loss of any asset can now be considered calculable for compensation. Furthermore, any individual might find herself/himself sued to compensate for loss attributed to her, her property, or her occupation. So ubiquitous is the idea of compensation for loss, and thus insurance against loss to the compensation of others, that it is considered essential that everyone is so insured. It has become a moral imperative that a person in contract with another (for ours is a contract society) is insured, not for one’s own loss but for the loss that one might cause another. As Mary Douglas (1992) puts it

‘The political pressure is not against taking risks, but against exposing others to risks.’ (Douglas 1992:15)

‘Of the different types of blaming system that we can find in tribal society, the one we are in now is almost ready to treat every death as chargeable to someone’s account, every accident is caused by someone’s criminal negligence, every sickness a threatened prosecution. Whose fault ? is the first question. Then, what action? Which means, what damages ? what compensation ? what restitution? And the preventative action is to improve the coding of risk in the domain in which it has turned out to be inadequately covered. Under the banner of risk reduction, a new blaming system has replaced the former combination of moralistic condemning the victim and opportunistic condemning the victims incompetence.’ (Douglas 1992:15-16)

The moral imperative not to injure another person requires now that one must be ready, *a priori*, to compensate for any loss of theirs for which one might be held responsible.

Those contracted to provide a service are particularly exposed to claims for damages and thus the expectation is that they will be indemnified for their practice.

No insurance, no contract¹⁰⁰

There is a problem arising from the expectation that the person entering a contract is an insured person. It is relevant to the midwives in this study, but in truth it affects not only the health system but every aspect of social contract. If the calculable loss (compensation claim) is bigger than the likely income (insurance premiums paid) it is not in the interests of a financial institution to bet upon (insure) it. If insurance however is a prerequisite to contract and particularly a contract to service, then certain services which are not profitable (for insurance companies) are without an essential of contemporary contract relationship. The power of money, property and now insurance carries with it significant power to determine then the social practices of a contract society. I will not expand here on this matter other than to draw upon the significance this power has on putatively public services such as health care provision, and in particular the choice to home birth. Some private health models and medical practices are sufficiently profitable and sufficiently numerous to sustain this mechanism whereby health practitioners and insurers make sufficient money to bear compensation claims. Some are not. Where birth has now (by a mechanism other than insurance, namely the professional closure strategies of obstetrics discussed in chapter seven) become almost entirely hospitalised, the practice

¹⁰⁰ **The uninsured are non-persons**

This assumption, for the good of the other, that the moral person will have insurance or the capability to compensate another has a dangerous edge to it. It assigns moral personhood (acceptability) not to a 'person in one's own property' which holds for the poor even if the contract economy perpetuates their poverty; the only morally acceptable person is one who has property enough to be insured against liability to another. The distinction is crucial. Personhood is apparently no longer attached self-possession but requires something beyond self-possession. It requires the wherewithal for insurance. The uninsured poor become socially and morally unacceptable, moral non-persons. The uninsured for any reason, including the uninsurable, those which financial bodies consider a 'bad bet', become defined as immoral. The contract economy, which has long abused the poor, made wage slaves where frank slavery has been theoretically abolished. It has, again, found the means to disenfranchise the poor. Those without property could previously at least sell their bodies and their labour. Now, without means to indemnify themselves from the potential of damaging others, they cannot even enter those most basic contracts. Those who would use them find their contract flawed.

Our contemporary definition of morally acceptable personhood excludes those who are poor because the morally acceptable contracting person should and must be insured.

The poor, I have argued, are not served by the political system. They have to bear their own losses because of the lack of insurance for themselves. Furthermore in order to be an acceptable social person capable of working interactions with others one must be insured. Without insurance one can remain as an isolated individual bearing no relationship to others; but once a contracted relationship is demanded so too is an insurance mechanism for the protection of the other. Without insurance, the uninsured are socially and morally unacceptable, they are outcast.

of home birth has become a minority activity. Practitioners of home birth are also then in a minority and their practices have become unprofitable for insurance companies.

As described above, the state government must decide the degree to which public or private medicine best serves its people. The state government must also decide then whether insurance companies should hold the power to determine which (most profitable) models of health care persist.

Summary

This chapter has outlined the development of health and indemnity insurance as an integral part of the professional contract in contemporary Irish society. Midwifery indemnification through state mechanisms (when for-profit insurance was declined) now allows for independent midwives to offer home birth to women who fit certain selection criteria. This is a mixed blessing for independent midwives who have gained considerable legitimacy through this mechanism, but thereby lose considerable professional autonomy to remain indemnified. The State has fallen far short of making home birth available to all women, depending only upon the decision of some midwives to operate outside the State employed acute hospital sector.

In many ways then Irish independent midwives are in a more comfortable position than their colleagues in the UK and the USA who remain unindemnified; or their colleagues in Australia who have recently been told it is illegal to practice without professional indemnification (Licqurish 2009). This turn of events places independent midwifery or those operating outside State maternity services, in the unenviable position of either conforming to orthodoxy or becoming criminals facing the full force of the law. Irish midwives have been spared that situation. However, the decision to practice only with clinical indemnity insurance or the alternative decision to practice without insurance, both have negative consequences. As with so many of the other dilemmas in independent midwifery practice, the ideal of promoting women's birthing autonomy comes into direct opposition to the demands of professionalism.

The expectation that contemporary professionals have indemnity insurance has been clearly demonstrated in this study. It has also been demonstrated to inhibit both women's birth choices and autonomous midwifery practice. Not unexpectedly, corporate financial

concerns seem to support the dominant patriarchal structures of contemporary maternity services over individual and woman-centred models. This alignment of practices associated with the State's backing of neoliberal policies in relation to health, and the suppression of women's reproductive and productive roles in society could certainly bear further consideration (see Murphy-Lawless, 2006 and Edwards, 2008). The inhibiting effect of indemnification as a moral necessity upon the concept of moral personhood also presents itself for further exploration than is possible in this thesis.

Chapter Ten Is ‘being with women’ incompatible with ‘being professional’?

Introduction

This section will draw together the independent midwives’ experience. It will revisit the demands of the day to day logistics of their practice and of their relationships with the mothers they attend and the other professionals with whom they work. It will particularly consider the dilemmas outlined in chapter eight and critique how the demands of professionalization (that is concern for their profession’s validation) compete with their efforts to support the woman’s birthing autonomy.

Integration of public and private

Following on from the work of Dorothy Smith (1987) about the everyday, I have examined the day to day experience and practice of independent midwives to reveal the relationship between women’s everyday experience and the more abstract operations of civil society. The description of their relationships with pregnant and childbearing women (in chapter four) demonstrates an extension of the private sphere into and integration with the public spheres. Carole Pateman (1988) argues that the separation of the public and private spheres has served to maintain patriarchy in public society. The valued abstract operations of the public sphere include politics, education and the commerce of the professions and trades. Yet unacknowledged and unpaid domestic and childrearing work are essential to maintain the operations of work in the public sphere. The private sphere is relegated and devalued compared to the public sphere. The relationship between the mother and midwife means the midwife must (and does) balance the demands of the public, paid work and abstractions to do with her professional life, and private, domestic work and relationships. Independent midwives, like so many women who straddle the public and private spheres of paid work and domestic personal life, manage, albeit at some personal cost, to integrate Hochschild and Machun’s (1989) first and second shifts, and Goffman’s (1973) front and backstage presence.¹⁰¹ Chapters

¹⁰¹ Each of these authors, like Smith (1987) and Pateman (1988), theorise on the artificially separated and differentially rewarded nature of personal/domestic and public or ‘work’ life.

three on the logistical demands of their work, and four on the relational aspects demonstrate a crucial aspect of the work of independent midwifery practice is balancing and integrating the two.

Exploitation, supply and demand

The tension between the private sphere of the midwife's personal autonomy and relationships, and the public sphere of her professional concern for and promotion of the woman's birthing autonomy, is seen in the potential for exploitation of the midwife (Benoit 1987, Annandale and Clark 1996) as discussed in chapter four section three. More particularly it is seen in the frustration midwives express when unable to meet the needs of all the women seeking birthing autonomy in home birth. Demand for professional support at home birth outstrips supply, and independent midwives know the cost of taking on too much. Solitary practice is discussed as unsustainable in the long run with independent midwives risking burnout in their chosen model of care (chapter four and Sandall 1997). Midwives also report that declining women seeking home birth is difficult (chapter eight, the freebirthing dilemma). Declining to attend a woman for home birth limits her birthing autonomy for she must then accept hospital birth with its manifest shortcomings (high intervention rates, see chapters five, section one, and women's loss of birthing autonomy, see chapters four section one and chapter six) or birth without professional assistance (chapter eight).

The centrality of relationship in midwifery praxis

Praxis is the lived practical expression of an ideology, theory put into practice (Friere 1970). Independent midwifery practice in Ireland is a lived critique of the dominant institutionalised, interventionist and controlling model of birth. Home birth is by definition non-institutional, and both mothers and midwives strive to minimise intervention and to maximise the mother's self determination in childbirth, called birthing autonomy (Edwards 2001, 2005). A key aspect of independent midwifery practice is also a lived critique of the cool, emotionally disengaged and professionally distant

practitioner¹⁰². Relationship is central to autonomy, as suggested in the concept of relational autonomy (Mackenzie and Stoljar 2000, see chapter six). Independent midwives deny that their professionalism requires that professional knowledge takes precedence over the woman's knowledges. They recognise that the safety of a trusting relationship takes time and personal engagement on their part. They decline to use their status as professionals to distance them from the women they attend. This lived ideological critique of what contemporary institutionalised birth has become, has its costs. Some costs are personal, as have been outlined, but most difficulties seem to derive from expectations and pressures of professional status and how that is perceived to function in our contemporary society.

The tension between birthing autonomy and professionalism

The major tensions for independent midwives appear not to be in balancing the simultaneous demands of the private and public spheres. The nature of birth as a personally engaged, physically embodied and socially supported process straddles the public and private spheres. Holistic, social models of birth resist categorisation as public; They espouse a personal relationship as promoting birthing autonomy and as such they present birth as deeply private (chapter four). Institutionalised and technological birth, which has become the dominant model, falls well within the public sphere and is ill-equipped to nurture the personal and relational aspects of birth (Mander 2001, Walsh and Newburn 2002a, and 2002b, Begley and Devane 2003a and 2003b). Midwives as trained professionals, without prior relationship or close familial or community ties with the mother, fall some way between these two models. They have considerable commitment to birthing autonomy in the social model (chapter six). Their claimed public status as professionals means however, that they have an awareness of, and must maintain a legitimising discourse within the public abstractions of professionalism and contracts of service (chapter seven). It is in maintaining the simultaneous discourses of 'being with woman' (promoting birthing autonomy) and professionalism that they express their

¹⁰² 'There is a real and unacknowledged sense in which the classic way of being professional – all-knowing, distant and detached – cannot be produced without the support of others; particularly, but not exclusively, nurses.' (Davies 1998:192)

greatest dilemmas. The competing discourses can be seen in all the dilemmas outlined in the previous chapter.

Many of the dilemmas considered in chapter eight can be grouped as expressions of the same compulsion, the profession's control of its membership through guidelines.

Guidelines, orthodoxy and control

Guidelines as professionalism and as professionalizing discourse

The three-part nature of professionalism was discussed in chapter seven. Professional status is predicated upon specialised knowledge being used for the service of others. The specialised knowledge is in turn used to justify professional self-governance. Professional guidelines are a means to maintain professions' claim to all three of these characteristics. As a discourse, guidelines articulate or 'prove' professionalism, and maintain professional power and authority; they are therefore a professionalizing or justificatory strategy.

The difficulty for midwives is that they want to lay claim to key elements of that professional status, namely the credentialisation that legitimises their title 'midwife' and yet in their practice they disclaim the use of possibly the central part of that status, that power and authority over the mother. Their discourse on birthing autonomy makes them deeply wary of abuse of their power.

The putative purpose of guidelines

Each professional practitioner is considered to be autonomous and competent to make decisions about her or his own practice. It is upon this premise that rigid external rules of behaviour, whether derived from the professional body or elsewhere are considered unnecessary, indeed anathema to much professional practice (professional autonomy chapter seven, section three, page 199).

Guidelines pander to this perception of professional practice as autonomous. Prescriptive rules or instrumental procedures, as in the manner of an algorithm, would infringe that autonomy. In this conception therefore guidelines are exactly that, a guide, not a rule or a law. Application should be individually tailored and thus not prescriptive. In the terms of

ABA's own guidelines to midwives, they state their purpose is to 'assist their decision-making' (ABA 2001).

Guidelines as discourse of power

Foucault's consideration of the techniques of power, and the leap from descriptive science (knowledge) to normative ethics (power) have been outlined in chapter five. Guidelines, I submit, operate in the same way. Using scientific methods, at best, but more often using contestable professional opinion, they propose putatively objective 'facts' about what is best practice. The word guideline carefully promotes the illusion of individual professional autonomy but guidelines have a normative effect. They become indicative of orthodox practice, and operation outside them is hard to defend as they represent the collective opinion of one's peers.

Guidelines as expressions of power

Andrew Symon (2006) describes the tendency for guidelines and protocols to lead to practitioners feeling constrained. He cites a 'regulatory creep' whereby layers of guidelines and protocols tend to undermine individual professional autonomy. This tendency is particularly the case in institutional and hierarchical settings as these features further over-layer the 'regulatory creep' with subordination and pressures to conform (Kirkham 1998 and 2003).

The power of self governance as a mechanism for promoting orthodoxy has been outlined in chapter seven. Fear of the use of guidelines to negatively critique midwife practitioners who stray from them has been mentioned in chapter eight. Guidelines can then not only diminish women's birthing autonomy but also midwives' autonomy. They are a double-edged sword. In supporting a degree of professional collegiality and evidenced 'good' standards of practice, they could rightly be called attributes of professionalism. As a means of articulating and enhancing profession knowledge status over women, they are inhibiting of women's birthing autonomy. Furthermore as a means of maintaining professional orthodoxy they inhibit, and can be used to expel, 'maverick' practitioners. In these last two manifestations, inhibition of birthing autonomy and maintenance of

orthodoxy, guidelines are means of maintaining professional status, power or authority. They are professionalizing strategies rather than attributes of professionalism.

There are two negative professionalizing strategies which underpin guidelines. Each strategy derives from a desire to control; to control birth,¹⁰³ and to control birth practitioners. Guidelines serve to undermine birthing autonomy and to undermine professional autonomy.

Midwives who promote birthing autonomy therefore contest guidelines in two ways. They refute the need, and tendency, to control women and birth, and they resist the normativising tendency of guidelines which, rather than promoting autonomy, actually inhibits individual professional judgement.

All the while however, the putative ‘good’ of guidelines which have become emblematic of ‘standards’ or ‘quality assurance’ are unassailable. No professional would advocate the lowering of quality standards, and yet querying the appropriateness of a guideline (or guidelines en masse) is to set oneself apart from the corporate body. Depending on the circumstances, it risks opprobrium at least from the profession for being unorthodox. The challenge for independent midwives is to maintain their profession’s imprimatur whilst trying to get back to the roots of the profession as servants of women and their families.¹⁰⁴ Independent midwifery praxis is a lived critique of the dominant model of birth. It is a critique of the dominant model of professionalism, which is ‘the professional knows best’. Their dilemmas therefore articulate the tension between the admirable qualities of professional service and the personal power inhibiting discourses of professionalization. It has proven difficult to admit, to profess that, one has skills and knowledge, without making the claim to that knowledge overbear the use of that skill and knowledge in service to the woman. Midwives, by denying the will to ‘know better’ are not denying their knowledge and skills, or those of their profession. They are merely, and significantly, placing their expertise at the service of, as subordinate to, the autonomy of the birthing woman.

¹⁰³ Which Jo Murphy-Lawless (1998) explains is a futile attempt to control risk and death.

¹⁰⁴ Mary Cronk (2000) *The midwife: A professional servant?*

Allegiance to the philosophy of ‘being with’ women makes relationship central to midwifery practice. Professional discourse claims superior knowledge and with it a moral obligation to control in order to achieve best outcomes. These two ideologies come into conflict in midwifery. The personal relationship cannot but be influenced by the knowledge / power disparity, indeed it is the basis for initiating the relationship. The personal relationship is however strained by the norms of professionalism and professionalization strategies. Professional discourses, particularly professional guidelines, normalise formality and distance conducive to the exercise of authority and interventionist orthodoxy. Rejection of these professional norms in favour of women’s birthing autonomy invites powerful professional counter-critique.

A reprise of the concept of autonomy

This section will review the link between the midwifery philosophy of ‘being with’ women, relationship and birthing autonomy which was discussed in chapter six.

Relational autonomy was proposed as a concept of autonomy that acknowledges social context and human relationship in autonomy (Mackenzie and Stoljar 2000). This section will explore not only the personal relationship between mother and midwife but suggest that the midwife acts as an intermediary, a facilitator in the broader maternity system. The section closes with a consideration of whether relational autonomy might be a model for understanding and promoting professional autonomy.

Being with, relationship and birthing autonomy

As was demonstrated in chapters four and six, independent midwives see women as being capable of birthing and that a supportive relationship will facilitate that capability. For midwives birth is a socially integrated event, and women’s power to birth is augmented by their relations with others. This relational enhancement of human capability, agency and autonomy does not fit well with a very individualistic, atomistic or separatist concept of autonomy. Making decisions for oneself, about oneself, does not require a denial of one’s relations with others but rather an acknowledgement that those connections and concerns form the important context of a decision (Mackenzie and Stoljar 2000).

Atomistic notions of autonomy also acknowledge the effects of context but interpret context only as diminishing of individual autonomy. Thus contextual considerations are understood as grounds to undermine the definition of autonomy and autonomy as a concept becomes entirely decontextualised. An isolated 'ideal type' is created but is untenable. A decontextualised notion of individualistic autonomy makes it useless as a working concept about how people decide in real situations. Assertions that we must be disconnected in order to be autonomous are not true in women's (O'Connor 1995, Hodnett and Federicks 2003, Edwards 2001 and 2005 and Hodnett et al. 2007) and midwives' (Berg, Lundgren and Wahlberg 1996, Lundgren and Berg 2007, Pembroke and Pembroke 2008 and Brown 2008) birthing experience (see also chapters four and six in this thesis).

'Being with' is a relational concept. The midwife and mother build a strong sense of relationship through continuity but also through mutual sharing (reciprocity) openness and respect. This leads to trust and, as Smythe (1998) and Edwards (2001, 2005) argue, more than a sense of, but actual safety. From this basis of trusting relationship and the encouragement and support of their birth partner, in this case the midwife, the woman can make decisions about her birthing, and also feel empowered in what is an unpredictable and demanding process.

'We need to view safety in the long-term context of the emotional wellbeing of families.' (Kirkham 1998:152)

Relationship is a resource which supports and which is flexible enough to meet the challenges of the uncertainty of birth. Those who would control birth want to intervene rather than let go, and they admit the essentially contingent nature of successful birth by only labelling it so retrospectively (Percival 1970). Edwards' (2005) concept of birthing autonomy therefore is a relational concept, which captures the nature of social support in birth to promote woman's choices, agency and self-determination. A personal and necessarily provisional approach maximises the chances of successfully negotiating the highly variable process and experience of giving birthing. A concept of autonomy as invalid under duress, cannot hope to cope with the demands of pregnancy and labour. The

danger is that such a conception defines labouring women as incapacitated, even incapable of autonomous behaviour and so removes all possibility of self determination. The professional then makes decisions ‘for’ rather than ‘with’ them.

The midwife as mediator of birthing autonomy in the wider maternity setting

Context then is important when considering autonomy. We have already established that relationship is possibly the most significant element in birthing autonomy. The midwife can mediate so many other aspects of the context that she is central in helping to maintain birthing autonomy for the mother. This extends beyond the immediate relationship with the mother. The midwife protects the birthing space for the mother; she is gatekeeper and sets the tone for those who enter that space. She is trusted to, and does, the work of managing the interface between the birthing woman and the outside world while the woman gives her resources to birthing. The midwife can be seen then to have a role beyond the immediate relationship with the mother, when she acts as mediator with the wider maternity system. Certainly, in decisions made by the midwives about whether to attend women, in the application of guidelines and in transferring to hospital, this mediation is seen as a real, and often stressful, role of the midwife. Again it can be seen as a relational role, a means by which the choice and decisions of the mother are facilitated, based upon the midwife’s knowledge of the mother and the mother’s trust that the midwife has her best interests at heart. The midwife must however bear the tension of post hoc examination of the decisions made and the potential for misalignment between her and the mother.

Relational autonomy as a model for understanding and promoting professional autonomy

Relational autonomy thus can consider the wider context of birthing and facilitate birthing autonomy beyond the immediate relationship. Can relational autonomy be expanded further to accommodate the issue of the individual professional’s autonomy within a profession ? Can the concept of relational autonomy enlighten professional autonomy issues ?

Chapter six on autonomy and chapter seven on professionalism both contained the concept of autonomy although in very different contexts. In the highly patriarchal setting of contemporary professions and in the competitive and justificatory processes of professionalization (Hearn 1982, Hugman 1991 and Witz 1992, all cited in chapter seven), an individualist view of professional practice pervades. The language of guidelines supports a conception of individual application of said guidelines, but as was discussed in the previous section (and chapter five) the coercive, collective and normativising functions of guidelines are quickly revealed under close analysis. While independent midwives struggle with this autonomy-infringing aspect of guidelines, perhaps there is scope, using a relational conception of even professional autonomy for identifying the strengths, not just the weaknesses of collectivity.

Independent midwives seek support from each other and a certain degree of collegiality. The Community Midwives Association, (CMA) the latest incarnation of that collegiality, has potential to support independent midwifery autonomy and perhaps have an even broader effect on all midwifery in Ireland. It may do so by encouraging peer review, shared working practices and by providing a counter-discourse (and collective praxis) to institutionalised birth practices. Midwifery supervision is not recognised as an uncontested good amongst midwifery writers (Demilew 1996, Way 2009), but it has potential for supporting midwifery practice, perhaps especially when that practice is challenged by orthodoxy. Midwifery supervision has long been neglected in Ireland (O'Malley 2002, but see also chapters one and eleven, the Commission on Nursing, Government of Ireland 1998, and Institute of Community Health Nursing 2007). The MOU between the HSE and independent midwives lacks a national mechanism for review. Supervision of midwives is a means for midwifery self-governance and thus a support for midwifery autonomy. The danger is, as with so much in professional practice, that supervision may be co-opted to the professionalizing project with its justificatory and status enhancing processes, rather than simply quality enhancement. The focus may become midwives and midwifery rather than those we ostensibly serve, which are women. The CMA has made preliminary steps towards peer review and they have

expressly set women's involvement into the process and as part of their longer term plan (CMA Peer review booklet 2009).

This review of autonomy and independent midwives' concern for women's birthing autonomy reminds us that women's birthing autonomy is based upon relationship. Relational autonomy, which acknowledges that context can actively enhance self determination, is a concept that might also accommodate professional collegiality in defending and enhancing professional autonomy.

A reprise of the concept of professionalism

The distinction between professionalism and professionalization

The distinction between professional qualities which comprise professionalism, and professionalization strategies, which promote and enhance occupational status, have been articulated in chapter seven. The distinction has also been referred to in the consideration of dilemmas (chapter eight) and even in the previous section on professional autonomy. The reason for this careful distinction is that professional service qualities are more than just 'claims'. Professional attendance at birth decreases perinatal and maternal mortality (Enkin et al. 1995 and WHO 2009 see footnote 79) professional knowledge and experience, support and appropriate intervention are demonstrably useful. Other aspects of less specific professional qualities, which derive from contemporary corporate business, managerial and customer care awareness such as courtesy, efficiency and timeliness, are widely regarded amongst service users as being of utility (Hughes 2006). Additional quality variables which midwives bring to their independent practice are generous amounts of time, personal relationship and individualised care. Professionalism then is not the element within 'being professional' that independent midwives find problematic, it is some other aspect.

It is professionalization, the justificatory rhetoric and practices which enhance the profession's (occupation's) status and power without serving women, indeed, at the cost of diminishing their power.

I will outline these, which have been alluded to already within the thesis. I will consider them in two sets, those which directly challenge women's birthing autonomy and then

those which undermine an individual professional's (in this case particularly independent midwives') autonomy.

The key professionalizing mechanisms that diminish women's birthing autonomy are, hospitalisation, mechanisation and diminution of relationship, which are closely interlinked.

Professionalization as diminishing birth autonomy

Hospitalisation

The move by medicine to concentrate patient numbers in hospitals (Foucault 1973, 1978) has inevitably led to hospital hierarchies that decrease patients' self determination, agency and control. Patients tend to conform (Lupton 2006). Lupton explicitly excludes hospitalisation for birth from a view that equates hospitalisation with illness (Lupton 2006:102). This is an exception that I feel might be premature given the problem of categorisation of so many women as abnormal or high risk in contemporary hospital practice. Specialisation too has been discussed (chapter seven) as a means to increase professional status but which devalues generalists, such as midwives, who can provide continuity and a total package of care.

Local, primary or community health care provision is popular with health service users (Kaufert and O'Neill 1993 and O'Neill and Kaufert 1995) and has been promoted by policy-makers as appropriate and potentially cost effective. As health service commentators such as Navarro (1984), McKnight (1994), and Lupton (2006) have articulated, the benefits to the professions of centralisation and the corollary inconveniences of community and primary health provision (including user involvement at the needs assessment, planning and ongoing implementation levels), make professional commitment to primary care tardy, if not at times downright obstructive. In Ireland community midwifery services are all but non-existent when compared to Britain and Northern Ireland our nearest neighbours. A HSE initiative to promote primary care teams (PCTs) has failed to integrate community midwifery services in their structures (DoH&C 2001c). The Domiciliary Birth Implementation Group (DBIG) was disbanded following the development of the MOU with no mechanism for national review and no promotion of an equitable, nationally available, domiciliary birth service. These are all indicators of

a lack of commitment to move maternity service away from a centralised and hospitalised model which serves the professionalizing strategy of medical specialism.

‘So we are coming from two different philosophies, you’ve got a medical philosophy and a more social model for a midwife and its just clashing.’
(p6L17 Int 09 Dec08)

Mechanisation

The conception of the human body and particularly the birth process as mechanistic (Jordanova 1989 and Martin 2001) has served to treat birth as amenable to a technical resolution. Technological intervention in birth has been discussed (in chapters five and seven) and time limits in birth have been facilitated by such thinking. Time too has become an aspect of institutional efficiency, where a business or factory model of birth becomes concerned with throughput, unit costs, manpower costs all of which enable an interventionist approach and allows active management of labour (for example) to flourish. Mechanisation and professional control of technology are professionalizing, status building strategies.

‘In deciding how to respond to the new technologies of birth, midwives face a troublesome dilemma: if they adopt the instruments of modern medicine, they risk sacrificing their distinctive tradition; if they cling to their tradition, they are marginalized as anachronistic, quaint, or perhaps, dangerous practitioners.’
(Devries and Barroso 1997:248)

Diminished relationship

Compartmentalisation of the pregnancy and birth process, as well as efficiencies of scale and multitasking in institutional setting, and even in community settings, all conspire to diminish the time-costly aspects of communication and human relationship building which mothers and midwives have shown underpins successful birthing (chapters four and six in this thesis, but also O’Connor 1995, Edwards 2001, 2005 and Hodnett et al. 2005 and 2007). Professionals cling to the superiority of their specialised knowledge. Their diminution of other knowledges, especially women’s personal experiential and embodied knowledges as irrelevant to the ‘management’ of birth, is a professionalizing strategy and not a quality of professionalism. Yes, professions have specialised knowledges, but it is the explicit privileging of that knowledge and devaluing of women’s

knowledge (made easier by not forming respectful, trusting and safe relationships) that is professionalizing and diminishing to birthing autonomy.

‘Here is an irony at the heart of midwifery: after a century of striving for professional status we find that very status and the structures of our profession separate us from the women we serve.’ (Kirkham 1998:123)

‘Yet if a midwife feels her first loyalty is to the woman she seeks to be ‘with’, then tensions are created with her professional role.’ (Kirkham 1998:124)

These three sub-headings, hospitalisation, mechanisation and diminished relationships capture some of the aspects of the professionalizing project that most undermine birthing autonomy. Other aspects of the professionalization, by detracting from individual practitioner’s autonomy, undermine independent midwives. The following professionalizing strategies make independent midwives fearful and inhibit others from supporting birthing autonomy in non hospital settings.

Professionalization, hierarchy and orthodoxy

Midwifery professional autonomy is diminished within hierarchies where medicine is explicitly promoted and maintained as the dominant profession. Midwifery in Ireland still serves its obstetric ‘Master’. The application of obstetric-led orthodoxies, expressed in guidelines, medical ‘opinion’, and institutional practice, is seen not only in hospitals but also in the disciplinary hearings of the midwifery profession (in chapter four, section two and chapter seven, section three which refer to the Aine O’Ceallaigh case). Savage (2007) and Wagner (2007) have described the witch hunting of obstetricians and midwives who promote women’s control over birth, as examples of the profession’s (particularly the medical profession’s) desire for control over birth. The peculiar status of ‘Midwives as Nurses’ in Irish statute (see chapter one) is another layer of professional boundary closure that inhibits midwifery autonomy by compromising professional peer review of midwives by midwives only.

Normal / abnormal and risk

The historical acceptance of the normal / abnormal delineation between midwifery and obstetrics (Witz 1992) has been used as a professionalizing strategy by obstetrics which

have continually enlarged the abnormal in its application of technology (George 1997 and Weir 2006) and the conceptualisation of risk (Murphy-Lawless 1998).

‘Indeed the division was highly ambiguous and it was the midwife who usually decided which labour crossed the boundary so ‘abnormal’ births were her province too. (Williams 1997:234)

Midwives have perhaps used their subjected position as a rationale only to defend their ground of ‘normal’, instead of articulating an expansion of normal well into the current domain of obstetrics. Take for example the potential discursive position that anything short of surgery might be considered normal. Twins and breech presentation for example have been construed and generally accepted as abnormal and high risk while, as common and natural occurrences that can be birthed by midwives without recourse to surgery, they could be claimed as normal.¹⁰⁵ They have not but arguably could be reclaimed by midwifery.¹⁰⁶

Midwifery prescription

A final aspect of professional closure that remains relevant to midwifery practice in Ireland is the lack of clarity in midwifery prescription. Prescription is a privilege that medicine guards most closely.¹⁰⁷ Recent provision for nurse and midwife prescribing in Ireland (ABA and NCM 2005, ABA 2007a, 2007d and 2007e) has attracted much attention but is very tightly restricted to specific employment posts and retains, at its heart, medical power to sign off on nurse and midwifery prescribers. Paradoxically this legislation has raised problems for independent midwives. Current interpretation of legislation regarding midwives’ freedom to obtain, carry, and administer drugs, fluids and medical gases in obstetric emergency are unclear and may be contested. Midwifery prescription is, it seems, accepted only as a post registration qualification, rather than an

¹⁰⁵ ‘In the interwar years both twin and breech births were considered normal and were attended by a midwife on her own responsibility, yet by the 1970’s such births had become the responsibility of doctors.’ (Susan Pitt 1997:229 footnote).

¹⁰⁶ Medicine’s willingness to give up certain more mundane ‘surgical’ procedures to midwives, such as episiotomy, perineal suturing, intravenous cannulation and even in some jurisdictions instrumental delivery and abortion (International Confederation of Midwives (ICM) 2008), mean these areas, normal /abnormal and surgical /non surgical distinctions, are already contested and ripe for further midwifery professionalization.

¹⁰⁷ Dentists and veterinarians are the other two professions which are explicitly mentioned in Irish statutes as having prescriptive authority.

at-registration qualification. Independent midwives are not (and by current arrangements cannot become) prescribers under the new legislation. This anomaly is a concern for midwives' professionalism but also for women's safety. Current arrangements of hospital standing orders for the administration of medication are primarily mechanisms by which medicine can maintain the authority of prescription as its own domain and explicitly not the domain of nurses (or midwives). They do not best serve the public.

Midwifery prescription and reclamation of definitions of normality however are professionalization strategies in their own right so I must be careful not to define all professionalization strategies as necessarily diminishing of birthing autonomy. It remains clear however that many professionalizing strategies have at their heart restriction of other professions' and particularly of lay persons' self determination.

Critique invites counter-critique

As independent midwives live and promote an alternative model of care that consciously promotes women's birthing autonomy, they offer a critique of the dominant model of maternity care in Ireland. Professionalizing strategies to control or stop their model of practice can be seen as attempts to silence that critique. The counter-critique of the powerful authoritative voices amongst the professions, calls into question independent midwives professionalism. The counter-critique also calls upon professionalizing mechanisms such as governance and guidelines to enforce their orthodoxy of control.

In the manner of feminist demands to study society from the perspective of the underclass (Stanley and Wise 1990, Rosser 1992 and Harding 1996), midwives have been prepared to critique medicine and obstetrics. By the same token, independent midwives too can critique hospital midwifery practice as colluding with dehumanising institutional practices. Who should critique independent midwives? Women. Particularly home birthing women. There are however few enough independent midwives willing to attend at home birth; women are in no position to be very choosy about the midwife they get. This does not promote women's selection of the better practitioner or service for their specific perceived needs. There is great danger that we may become vainglorious, characterising ourselves as saviours of birthing autonomy and keepers of the flickering

flame of home birth. We are not perfect, but in our willingness to see the eagerness of our detractors to resort to fair means or foul in their own professionalizing project and mechanisms of professional closure, we may not either see or feel the need to examine our own relatively powerful positions in the home birth arena. One of the early challenges facing the CMA is more than remaining genuinely reflexive in our peer review of our care, but how to address complaints from mothers about actions (or omissions) on the part of an independent midwife.

Chapter Eleven Conclusion

This final chapter will draw together the major themes identified in the study. It is presented in two sections: the first mirrors the opening chapter which situated home birth and midwifery in Ireland at the outset of the study. It resituates home birth and midwifery in the light of changes since the turn of this century and particularly the period of the study (2006 to 2009). The second section of the chapter critically examines the independent midwives experiences in relation to broader social and theoretical concerns.

Resituating home birth and midwifery in Ireland

Direct entry midwifery

A four year direct entry to midwifery undergraduate programme began in Ireland in 2006. The first cohort with an annual intake of 140 students nationally, will graduate and be available to the workforce in 2010. Certainly as students this cohort has the potential to bring a healthy questioning of institutionalisation and the pathologising of birth. They can already articulate deep concerns about the pressures they will face to conform within institutions where the majority of them will practice (Mander et al. (forthcoming) Murphy-Lawless et al. 2009 unpublished report). Compared to their post-nurse registered colleagues they have not been pre-socialised into operating in hospital hierarchies before encountering midwifery. However, they are training in hospitals which continue to adhere to a rigid hierarchical system, which also continues to provide protected access to facilities for the private fee-paying patients of consultant obstetricians. Whether direct entry midwives can maintain a vision for normality in birth in hospital and act as advocates within this hierarchy and in a structure increasingly under pressure of time and throughput is another question. Many have expressed an interest in attending women for home birth and in theory, they are officially eligible to practice midwifery at the point of ABA registration. There is a difference of opinion even amongst independent midwives however, about the wisdom of such a move. Newly registered midwives would certainly benefit from having experienced support initially.

The HSE and independent midwives, the benefits and constraints of the MOU

The memorandum of understanding (MOU) between the independent midwives and the HSE for the provision of home birth services was discussed in chapter one and chapter four, section three has freed independent midwives in Ireland, to an extent, from having to practice without professional clinical indemnification. This means that home birth midwifery has at least been rescued from the prospect of becoming illegalised, which scandalous situation faces women and independent midwives in Australia (Licqurish 2009). The MOU does not however address the provision of services to women who lie outside its terms. Irish women and midwives still face the dilemma of unindemnified practice in such cases. This is a stark retrograde step arising from the ‘Freedom to birth’ document (HSE 2008) which proposes a national framework for the indemnification of independent (self-employed) midwife attendance at home birth, but no longer countenances women choosing home birth outside its criteria.¹⁰⁸

The MOU also unaccountably requires three year post-registration experience for midwives wishing to work within its terms.¹⁰⁹ New midwives are thus effectively unable to access payment and insurance cover for home birth practice despite being officially eligible at the point of registration to practice midwifery in any context. The three year exclusion makes no indication about what kind of experience might be suitable and will certainly act as a disincentive to the new cohort of direct entry midwives from leaving hospital practice and commencing domiciliary practice. That in itself may be the clue to the purpose of the unexplained restriction.

Furthermore there is no national structure for review of the MOU which makes it impossible to address implementation difficulties or renegotiate aspects of the MOU.

As guidelines have been so central to the independent midwives’ discourse about professionalism, inability to negotiate them is a particular frustration.

¹⁰⁸ As suggested in the Southern Health Board document: ‘Home birth contrary to midwifery and medical advice’ which is contained in appendix four, the provision for attendance in such cases was at least considered prior to the 2007 memorandum.

¹⁰⁹ It became clear that this proposal actually came from one independent midwife. It was offered out of a genuine concern for experienced practitioners to attend mothers, but apparently without insight into the broader potential consequences of that suggestion.

Education and training standards

The ABA (2000b) introduced changes to the education and training standards for midwives requiring two weeks of community midwifery experience as part of the course requirements. This has been difficult to facilitate but with the few DOMINO and home birth schemes, midwifery-led units, early transfer home schemes and antenatal outreach clinics as well as elective placements in the UK and other EU countries, there should be opportunities to give the student some exposure and experience outside obstetrician led, acute hospital working practices.

Eighteen month post-registration midwifery

The post (nurse) registration education programme for midwives was recently reduced from two years to eighteen months (ABA 2007). This is potentially a loss to midwifery as the midwives qualifying have had less exposure to learning support during their education to counter the unfavourable conditions of practice in large-scale maternity units which dominate their training. They have limited employment mobility within the EU until they gain at least one year's experience in practice. This follows the model that has been in place in the UK for many years. The eighteen month post-registration has diminished as the main point of entry to midwifery in the UK and the same pattern may be reflected here.

That midwifery registration is no longer an entry requirement for public health nursing (PHN, ABA 2005) and this may mean that there will be better retention of midwives in the maternity services as fewer will see midwifery as a stepping stone to PHN registration. Unfortunately however there will inevitably be less midwifery expertise amongst PHNs with consequent loss of antenatal and postnatal support in the community, a critical issue in the Irish context where community midwifery is negligible. The place of directors of PHN as supervisors of midwifery has been eroded since the withdrawal of State domiciliary midwifery services. Supervision has been discussed in chapters one and four and will be addressed again below.

AMP and CMS posts

The use of Advanced Midwifery Practitioner (AMP) and Clinical Midwifery Specialist (CMS) posts (and their nursing equivalents) as a mechanism for enhancing staff promotion structures and retaining clinical skills may have served nursing well (NCNM 2008, 2009), but as discussed in chapter one this model follows a medical model of specialisation as a route to status and professional standing. Specialism in nursing has led to compartmentalisation of care and reduction in continuity and holism all of which midwives strive to resist but which is replicated in the fragmentation of midwifery care in many hospitals into antenatal, intranatal and postnatal areas. Unfortunately the objective for these posts in Ireland seems to have precluded the recognition of support for normality in birth as sufficiently specialised or advanced to justify higher clinical status and salary. As was outlined in chapter one, of only three AMP posts (compared to 25 ANP posts, NCNM 2009) ratified to date, two are in specialisms (diabetes and urodynamics) and only one, as yet unfilled, in normality support. All CMS and AMP positions are attached to particular employment sites and settings, usually in the acute hospital sector; such positions are not available to independent midwives as HSE salaried community midwifery positions do not exist.

Nurses and Midwives Act and the Department of Health and Children

The long awaited amendment to the 1985 Nurses Act, which should change the title to the Nurses and Midwives Act, has still to be enacted. It should reinstate the statutory midwifery committee within ABA. This may be the genesis for change in the make-up of midwifery fitness to practice panels of ABA which currently may include nurses or those with no midwifery experience beyond registration. The proposed act also brings the possibility for a domiciliary midwife to serve on the ABA midwifery committee.

Given that some five different departments within the Department of Health and Children have some jurisdiction over birth and midwifery, it is difficult to lobby for a concerted policy approach. Similarly, although there is a nursing and midwifery education officer within the DoH&C, there is no longer a midwifery officer to whom to bring midwifery,

not to mention domiciliary midwifery concerns. The undermined position of midwifery within An Bord Altranais has already been discussed in chapter one and we still await the proposed Nurses and Midwives Act amendment which was recommended in the Commission on Nursing in 1998. Consultant obstetricians and doctors generally hold considerable sway in the formal decision-making processes (DoH&C), lobbying (Comhairle na nOspideal) and health care delivery bodies (Health Service Executive and maternity hospitals) in Ireland. Doctors' influence, even at the level of the Supreme Court in Ireland, was seen in the 2003 ruling that home birth was not a right supported by Irish statute.¹¹⁰ These power positions facilitate what Savage (2007) and Wagner (2007) identify as the obstetric desire to control birth, and tellingly, the State backs this desire, privileging obstetric authority. The decision to practice midwifery outside the hospital setting may well reduce the effects of hierarchy and institutionalisation but it cannot avoid these wider systemic and structural components.

Maternity Services Restructuring

Major redistribution of the acute hospitals budget for maternity services to the Primary Continuing and Community Care (PCCC) budget is unlikely. The possibility of establishing a community midwifery service probably still lies largely within the power and remit of the acute hospitals in the roll-out of community midwifery services. The KPMG report on Dublin obstetric and gynaecological services (2009), has promoted the idea of midwifery-led units in maternity hospitals attached to large tertiary general hospitals with neonatal intensive care and paediatric surgical services. It very frankly promotes a three hospital model for Dublin because three hospitals already serve the purpose. That is hardly a visionary response to an already overstretched service. While the promotion of midwifery-led care is a crucial development for midwifery, such a model accentuates the already-centralised and centralising moment in Irish maternity services. The danger is that such a solution (centralisation and concern for sub-specialities of medicine) proposed as appropriate for Dublin, might be rolled out without due consideration to the rural nature of the rest of the country. In the current economic climate, where public services are being targeted in substantial cost reduction exercises to

¹¹⁰ See footnote 83 in chapter eight page 232

address the domestic budget deficit, it is unlikely there will be any major allocation of funds for restructuring.

Primary Care Teams

Primary Care Teams have been promoted, receiving seed funding in sites throughout the country in response to the Government health strategy document 'Primary Care: A new direction (DoH&C 2001c). At the same time, it is apparent that although community midwifery is mentioned,¹¹¹ no national integrated community midwifery service is proposed and no midwives make up any of the current teams.¹¹² It seems likely that community maternity services will decline further highlighting the inequity on the island between midwifery services in Northern Ireland which comprises home visits by a community midwife for ten days postnatally and up to 28 days if needed.

Midwifery prescription

Relatively recent legislative changes to facilitate nurse and midwifery prescription were introduced in 2007. This is a significant move towards recognition of the role of non-medics in appropriate drug management. The ABA have been closely involved in providing guidance to nurses and midwives on medication management (ABA 2007a, 2007b and 2007c) but also in the development of the initiative (ABA and NCNM 2005, ABA 2007d). Those of us who would like to see more explicit prescribing powers given to midwives as a part of their essential role in providing safe midwifery care, especially in obstetric emergency, have been frustrated by this process.

As the prescribing course and registration of midwifery prescribers has become more widely available, it seems that those without this course are being more explicitly denied the right to prescribe. Midwifery prescription, or at least the power to obtain, carry and administer emergency drugs at home birth, persists in a regulatory loophole that is threatened to be closed. ABA 'Guidelines for Midwives' (2001) states that the chief pharmacist considers various drugs should be available to midwives attending home

¹¹¹ Independent midwives talk about independent midwifery and home birth being a unique opportunity for the HSE to provide a model for community care services in keeping with DoH&C (2001c) priorities (p1L35 FN 21Feb08).

¹¹² Post-natal community care remains the remit of PHNs whose training no longer requires midwifery and may consist of a short maternal and child health module (ABA 2005).

birth. It appears that the new chief pharmacist may not be of that opinion. The independent midwives' access to these drugs depends upon local pharmacists' interpretation of this advice from ABA. In its strictest interpretation these drugs may only be available on prescription to particular women. If this view is taken, it can clearly be interpreted as an instance of professional closure by medicine (facilitated by statute on medication). Independent midwives', and others' including midwifery teachers', view is that midwives must be able to obtain, carry and administer these drugs on their own responsibility.¹¹³ Any other arrangement, such as exists in hospital standing order, is a fudge of the situation where midwives are the professionals who judge when the drugs are necessary and determine their appropriate use. Every midwife at the point of registration must have this skill and the educational preparation to support it. If this has not been made explicit in their educational preparation, it is in part due to the lack of clarity of the legislation. Prescribing is not absent in their curriculum: all midwives have been so prepared even if the position of the current chief pharmacist and other complex demarcation issues may need to be made more explicit. This is a professionalization issue and may be a product not only of medical professional closure strategies, but also a product of the subsumed status of midwifery 'as nurse' within the ABA reflecting divergent professionalization strategies for nurses and midwives (see nurse-midwifery conflation chapter one and professionalization in chapter seven).

Expansion of hospital-based community midwifery schemes

There are several local schemes to provide choice in maternity services. The most radical (in Ireland) has been the development of midwifery-led units in Drogheda and Cavan. An evaluation of these and a randomised controlled trial (the MidU study) is expected to report shortly (Devane, Begley and Clarke 2006). Other hospital-based and integrated home birth schemes exist in Dublin National Maternity Hospital (NMH), Waterford and Wexford. There are DOMINO schemes also in these hospitals and in the Rotunda (Dublin). Other initiatives such as midwifery-led early transfer home schemes exist including one from the Coombe Women's Hospital (CWH, Dublin). As outlined in

¹¹³ This concern was expressed in submissions to the DoH&C on the proposed amendment to the 1985 Nurses Act (Nurses and Midwives Heads of Bill) by the independent midwives and midwife teachers in Trinity College Dublin.

chapter one, several maternity hospitals and PHNs have facilitated home birth requests in the past. All of these are examples of opportunities for community midwifery as part of acute hospital outreach. They not only increase maternal choice in these limited geographical areas but also have potential for increasing student midwives' and midwives' exposure to community and domiciliary care. Such piecemeal and acute hospital dependent services are a far cry from a national community midwifery service, but they do indicate an opening up of choice and debate on appropriate place of care for childbirth. Independent midwives still play the major part in the delivery of domiciliary services and the perceptions people (particularly other health professionals) have about home birth. As discussed in chapter eight, the political actions of independent midwives and their public reputation are important in shaping these perceptions. As discussed in chapter four working relationships with other professionals are extremely important in this regard. The independent midwives' work on the DBIG and their continued involvement in domiciliary birth implementation committees has been and continues perhaps to be vital to helping to gain greater acceptance and mitigating somewhat the view of them by other professionals as maverick outsiders. As has been seen in the strictures within the MOU however, acceptance and respectability – strategies of professionalization - have costs for midwifery autonomy and for women's choice and birthing autonomy. As discussed in dilemmas (chapter eight), the stakes are high and the pressures to conform are great but somewhere the midwife has to draw the line, strike a balance and decide that birthing autonomy and midwifery autonomy are worth the personal costs of refusal to conform.

The Community Midwives Association (CMA)

Calvert (2002) suggests it is time for midwives to address the socio-political constructs in healthcare. It cannot be done without a collective vision. The Community Midwives Association (CMA) might form the kernel of a collective vision for domiciliary midwifery and begin to give it voice for the collective action that is now vital.

The formation of the CMA is an attempt by independent midwives to establish a professional body to address their (our) particular professional concerns. It had its basis in the midwives' response to the withdrawal of insurance by the INO and negotiations

through the DBIG that gave rise to the MOU. The CMA has already produced a document proposing a format for peer review to meet the requirement of the MOU that the midwives have some sort of governance and audit process. Other issues that will need to be addressed by the group are the handling of complaints about individual practitioners and the support of individual midwives in difficulty. There seems to be reluctance for the CMA to take on formal supervisory functions, not least because they, neither individually nor as a group, have statutory sanction to do so.

Supportive Midwifery Supervision¹¹⁴

While the 1985 Nurses Act removed the need for hospital midwives to notify their intention to practice midwifery, notification remains necessary for independent midwives. It has been proposed, in submissions by the independent midwives and others that legislation should apply to all midwives equally rather than singling out non-hospital midwives. PHNs, and midwives, have pointed out the inappropriateness of this in contemporary maternity services (Government of Ireland 1998 Commission on Nursing, Institute of Community Health Nursing 2007). The requirement to notify one's intention to practice might be the precursor to supervision of that practice. Mavis Kirkham's two edited collections on the supervision of midwives in the United Kingdom (1996 and 2000b) investigate the 'community of supervisory roles' (1996:10) and express the concern that midwives have that the policing and controlling functions of midwifery supervision are counter to clinical autonomy whereas a supportive, a 'midwifing of midwives' is possible and necessary. One would imagine that, with the amendment of the 1985 Nurses Act, supervisory arrangements so long neglected, could be implemented shortly thereafter, though who would fulfil that function is unclear. Hospital directors of midwifery (personal communication with Dublin Area Maternity Hospitals Directors of Midwifery 27 April 2009) seem reluctant to undertake that extra role and the consequences for further encroachment of a hierarchical and managerial attitude to supervision might be anticipated if they were to be given, or take on this role.

¹¹⁴ Although Galper (1975:58) some time ago argued that the supervisory relationship is the source of 'never-ending subordination of the practitioner.' These concerns remain and with good reason. See Stapleton, Duerden and Kirkham (2000).

The key question is how can midwives gain supportive and knowledgeable supervision in the context of the multiple demands of home birth which differ so significantly from the demands on midwives in acute hospital settings.

Mavis Kirkham has argued that support is vital:

‘Support of all sorts is essential if we are to achieve the confidence as midwives to outgrow the scapegoat responses of professionalism. Then we can develop the flexibility to find an appropriate balance between our need to feel in control of our work and each woman’s need to feel in control of her experience.’ (Kirkham 1998:150)

Such is the isolated nature of many independent midwives’ practice, that some sort of support network, other than informal networks and friendships, should be available to them when they face difficult practical and ethical decisions in their day to day practice. Very often it is their isolation that leaves their actions and intentions invisible to concerned scrutiny. Supervision would at least offer a mechanism for them to share their dilemmas and their rationale for action, or non-action. This simple transparency might contribute to creating greater understanding of what home birth practice comprises and to allaying the concerns of other professions and fellow professionals when outcomes have been less than perfect. The policing and controlling aspect of supervision however persists in the Irish legislation and even in the UK (Way 2009). In Ireland there is a concern for the reputation of independent midwives as a collective, and at the same time there is a real need for building collegiality amongst quite a dispersed and diverse group.

Although the independent midwives have avoided using the word ‘supervision’ for their newly introduced peer review processes (CMA 2009), it is, in effect, a form of peer supervision and reflects the modes used in best practice social work and psychotherapy. Such supportive supervision for, rather than control of domiciliary midwives is necessary (Taylor 1996, Stapleton, Duerden and Kirkham 2000). Supervision must carefully nurture mothers’ choices and birthing autonomy and individual practitioner’s autonomy.

Second on call

Having a second midwife available for a birth may be a support for midwives in domiciliary practice. Yet it may not, and it may not be the choice of some mothers. The independent midwives on the DBIG were very clear that they wanted no absolute requirement to have a second midwife at every birth. They felt that that would signal the death knell for home birth in Ireland, given the few midwives willing and available to support home birth. This argument was heard by those on the DBIG and in the HSE. Nonetheless, the consensus was, and seems to be that it would be preferable and considered best practice, (remembering as with any guideline this can have a normative function; in this case it is expressly normative but leaves room for manoeuvre). Those who have had a second midwife present when birth has not gone as hoped and emergencies have presented, have felt enormously supported by the corroborating presence of another professional (see chapter four). It is exactly the corroborating or verifying effect of another that produces some transparency and eases concerns about potential malpractice or charges of malpractice.

In summary, this section considered several contextual changes afoot in the midwifery and home birth arenas. Some have the potential to facilitate, and some to diminish, home birth choice, birthing autonomy and midwifery. Independent midwifery praxis sustains home birth and midwifery autonomy. Collective political engagement by independent midwives and mothers has brought some benefits (such as indemnification and independent midwifery peer review) and it has the potential to bring more.

Critical reflection on the independent midwives' experiences

Critical ethnography requires a certain reflexivity, that is, it should contain a reflective account of the particular micro-social experience within the wider macro-social context (Foley 2002, Singer 1990). This section will consider how the experience of independent midwifery, the logistics, relationships, dilemmas and the central tension between birthing autonomy and professionalism speak to wider social theory. The critical themes that will be considered are power, fear, love and ethics.

In the thesis I have described the life and experience of being an independent midwife in Ireland in the twenty-first century. There are practical considerations that have to be addressed to allow a midwife to balance the demands of her personal and professional life. The main attribute of independent work is the flexibility it allows. That attribute is balanced however with a need for flexibility, on both the midwife's part and on the part of her family.

Home birth choice is severely limited, numerically and geographically; it is vulnerable. The midwives who offer that service are also vulnerable, professionally, legally and economically (chapters eight and nine). Even those within the acute hospital system who have domiciliary schemes feel vulnerable to their blanket withdrawal in reaction to local accident or incident.¹¹⁵

Despite their withdrawal from the strictures of hospital hierarchies, independent midwives' autonomy remains restricted by a memorandum which ties their indemnification to conservative and risk-averse home birth suitability criteria (chapter four, section three and chapter eight).

It is perhaps unsurprising then that there remain few midwives in Ireland who are willing to attend women for home birth.

Power

Power manifests itself in many ways in birth, not only or least in the woman's power to give birth. Despite being a midwife teacher and having worked within Irish maternity services (North and South) for nearly two decades, it has only been through the processes of doing and studying home birth that I have come to recognise some of the power structures surrounding Irish birthing practices. The power relationship between the

¹¹⁵ Despite the infrastructure (pools) now being available in many maternity hospitals, water birth has been nigh on impossible to negotiate since the death of a baby three days after his birth in water in the Midwifery-led Unit in Cavan in February 2006. Water births put on hold, Irish Independent, Monday 16 June 2008, <http://www.independent.ie/national-news/water-births-put-on-hold-after-death-1410945.html>. Accessed 17 September, 2009.

Irish Independent (Georgina O'Halloran) (2007) Water-birth death inquest: witnesses may be recalled Saturday July 28 2007

<http://www.independent.ie/national-news/waterbirth-death-inquest-witnesses-may-be-recalled-1046867.html> Accessed 16th September 2009

woman and her midwife is one that has not been ignored in this thesis nor by the independent midwives themselves. Unlike the community midwives studied by Floyd (1995), these midwives seem not to need to control birth at home. Mary Cronk (2000:23) nicely summarises the main problem for midwives striving to promote women's birthing autonomy:

‘One of the problems of professional status is the assumption that the expert knows best and that power is inherent in expert knowledge and opinion.’

As Kirkham (2003:13) found in birth centres in the UK however empowerment of women is possible despite ostensible power differences between mother and midwife:

‘It [small scale of birth centre] can allow a shift in power from the professional toward the woman.’

This certainly concurs with my observations in the work of independent midwives in Ireland. For too long the discourses of risk management, actuarial calculation of loss, the business rhetoric of efficiency, centralisation and rationalisation have been allowed to dominate and be co-opted by medicine to its own professionalizing purposes.

‘Providers, policy makers, and the population at large absorbed the ideologies that the pursuit of self-interest is the highest form of ethics, that competition is the motor of society, that productivity and economic growth are society's most important goals, and that the market has spoken – and has blessed medical inequity, if not inflation.’ (Perkins 2004:161)

‘As health planning mistook its consumer-majority committees for democracy, market oriented reform mistook the reduction of government regulation for democracy, a common fallacy.’ ‘Neither planning nor the market was democratic in the sense of distributing decision-making power.’ (Perkins 2004:167)

Midwifery stands as an alternative to obstetric rationality. There is the possibility that any counter-discourse to obstetric rationality might be labelled as midwifery's own professionalizing or justificatory rhetoric. We must not however shy away from that accusation to the extent that we offer no alternative discourse. Contemporary institutionalised maternity services are manifestly unsatisfactory to women who use

them,¹¹⁶ despite what inadequate satisfaction surveys might indicate. What is, must no longer be accepted as what is best. Better birthing is possible and Enkin et al.'s suggestion (1995) that automatic involvement of an obstetrician is unlikely to promote best outcomes, still holds.¹¹⁷ As the other significant profession in childbirth, midwives must be very clear about what it is we can offer and make it our aim to provide it. We know women want choice, continuity and control, and that institutionalised care cannot adequately meet those requirements, although small units and midwifery-led care can. In every setting however there are opportunities for positive change – perhaps the single biggest change in the Irish context is to model services and systems that positively engage women in determining the structure and delivery of services to suit their needs. If, as it seems, we cannot immediately provide community midwifery nationally, (and yet we must continue to press to do so) then models of midwifery outreach such as exist in Cork, Waterford Wexford, and to some degree in Dublin (chapter one) need to be actively supported, expanded and defended against those who would threaten their closure.

Midwives in hospital settings are potential allies of home birth independent midwives, particularly when they resist the anxieties and pressures of the systems within which they work to support and advocate for other models of midwifery. I hope that this thesis demonstrates to non-independent midwives that theirs is a common cause with women. Not all women want the same thing however. The alliance of midwives and women has potential, because of the strength and autonomy-boosting nature of relationships, to effect positive change; not only individually but also in broader society. Many women and many midwives know the power of good birth. Working and speaking together they must acknowledge that power, that potential and demand good birth for all. Good birth is not an issue only for individual women. Human reproduction is not 'just a woman's issue', it is of greater, not lesser, importance than human production, the concerns of global

¹¹⁶ For example, see Edwards (2005), but see also the birth stories that are consistently published by women online in mothers' groups and in childbirth activist newsletters and journals. The Association for Improvement in Maternity Services (AIMS) publishes a quarterly journal which has as its linchpin, women's accounts of how they struggle to achieve birthing on their own terms within hospital structures.

¹¹⁷ 'It is inherently unwise, and perhaps unsafe, for women with normal pregnancies to be cared for by obstetric specialists, even if the required personnel are available.' (Enkin et al 1995:15)

capitalism and the market economy. Birth is more important and more central to human existence.

‘Symbolically and materially, women and reproduction – seen as an integral part of social and political action – must be accounted for in social theory.’
(Weiner 1995:420)

‘Neoliberalism does a number of things: it reduces pregnant women to consumers, likening having a baby to a trip to the supermarket, where we can ‘choose’, but only from the ‘choices’ available, and only if we can afford to.’(Edwards 2008:465)

There is more to birth than getting a baby out. Midwifery and the independent midwives in this study recognise this fact and put that knowledge into practice. It is a difficult praxis, but rewarding, and offers an alternative vision for those who would reflect upon the consequences of contemporary birth.

‘... the place of birth is a sign – a symbol of cultural alignment. The choices are acts of defiance, intimidation and persuasion. Having a baby at home is wielding a weapon – the home is a badge of allegiance; just as modern technology in the form of the electronic fetal monitor is a badge of allegiance. Choosing the tools and approaches to birth is declaring dogma. Childbirth demands constant attention. Pressed hard by enemy forces, it calls for constant vigilance, subtlety and resourcefulness.’ (Hillier 2003:123)

Fear

Fear and dread can hang over independent practice (chapter eight). Midwives do not fear birth, but fear that their professional decisions may be called into question. This fear seems almost to be a direct result of working alone within a society largely unresponsive to the value of community-based midwifery. An increasingly risk-aware and risk-averse society where a compensation culture pervades, means that the threat of malpractice suits hang over the heads of birth attendants like the sword of Damocles. Rather than feeling supported by their profession, independent midwives feel vulnerable to its exercise of power, vulnerable to its remit to control its membership. As some independent midwives have recorded in this study and as independent midwives in the UK also point out, it is very difficult for the unorthodox to defend themselves from suspicion of idiosyncrasy or outright bad practice (Jowitt 2008).

People fear what they do not know, they suspect the hidden or the occult. Independent midwifery practice, because it lies outside the realm of orthodox obstetric practice and control, attracts suspicion. Independent midwives have little to fear from having their methods examined, what they do have to fear however is the application of norms and standards from institutional orthodoxy. In contemporary maternity services, the term 'governance' is used as a blanket term to signify the self-governing functions of autonomous professions. Independent midwives in their negotiations in the Domiciliary Births Implementation Group (DBIG) and in the memorandum of understanding with the HSE, have decided that self-governance in the form of peer review is more palatable than the prospect of external governance either by obstetricians or non-independent midwives. Women's birthing autonomy is central to independent midwifery philosophy and practice. Independent midwives (and home birth mothers) live a critique of contemporary institutionalised birthing practices. Home birth needs to be protected as a choice and in Ireland and it is not, despite the recent and very significant decision to indemnify some home births. Home birth is tolerated at best and certainly not promoted. Midwives, because they are professionals recognised by the State, are potentially more vulnerable even than mothers to regulation. The nature and degree of regulation seems to be the key to the future of domiciliary midwifery in Ireland. Keeping one's head down is an understandable response to vulnerability but it comes at the cost of seeming ashamed and having something to hide. Fighting for political recognition invites harsh opposition and self-seeking protectionism from others, but independence need no longer mean isolation.

Love

Several authors have written of love as an aspect of caring (Graham 1983, Campbell 1984, and Smith 1992). In this thesis I have considered relationship and 'being with', and I have aligned them with the concept of autonomy. A relational conception of autonomy (Sherwin 1998, Mackenzie and Stoljar 2000) acknowledges that individuals' autonomy is enhanced, or inhibited by their context and their relationships with others. Relational autonomy, unlike a highly individualistic or atomistic conception of autonomy, does not attempt to deny context and relationships. What this study suggests is that 'being with' facilitates autonomy in more than instrumental ways. Like caring, 'being with' is in no

small part, affective. Human affection, or love, is the essential element that must be integrated into relational autonomy to make it a more adequate concept.

As Hilary Graham (1983:15) points out:

'Where the word 'love' seems inappropriate, we choose the words 'care for' to convey a sense of the bonds which tie us to our friends, our lovers, our children, our parents, our clients, our patients.'

What she does not explore however is why the word 'love' might be, or seems to be inappropriate in describing the professional caring relationship.

Pam Smith (1992), Hilary Graham (1983) and writers on emotion work in nursing and midwifery such as Billie Hunter (2002, 2004 and Hunter and Deery 2008) acknowledge that Hochschild's concept of emotional labour does not quite fit with the caring professions. While caring work is recognised as highly emotional (or affective) the contract of employment does not directly regulate or reward emotional presentation. It seems from commentary by writers such as Sharon Bolton (2000) and Tyler and Taylor (1998) that one of the major aspects of caring or 'women's work' is that emotional 'extras' or affective generosity must be otherwise explained. It is explained either as essentialist 'woman' work' (Graham 1983 and Smith 1992) or a socially contracted 'gift' (Taylor and Tyler 1998, Bolton 2000). Emotional caring is unremunerated and yet it is also entirely expected; it is socially ritualistic and, in Tyler and Taylor's construction, a 'compulsory altruism' (1998:169).

This one-sided and highly gendered selflessness expected in the caring role (gendered women's work) is a challenge to my feminist principles and so I resist the notion as another expression of the unfairness of patriarchy. I feel the urge to denounce it as unfair and yet, in my experience and in this study I have seen that caring, loving generosity is both appropriate and satisfying. It is the fulfilment of the relationship.

I wish to leave this thought for a moment and consider another aspect of caring professionalism that has been alluded to earlier in the thesis, and that is professional distance. The same authors, Graham (1983), Smith (1992), Tyler and Taylor (1998) and Bolton (2000), maintain that much of the emotional labour inherent in caring work is the control of emotions in order to maintain 'appropriate' emotional distance. Again, in my experience as a midwife, and from observation and conversation with independent

midwives, I have come to understand that the idea of professional distance is contrary to the promotion of birthing autonomy through relationship.

Why should emotion and emotional involvement be anathema to professionalism? To care is to be engaged emotionally affectively, to pretend otherwise is dehumanising. I can laugh and drive the car at the same time. I can write and weep at the same time. When I am afraid, my senses are heightened. I am designed to make good survival decisions in extremis. Why should work, especially human caring work, be denuded of emotion ? Why should we encourage emotional distance, which we all know is damaging to relationships, to support and to real (relational) autonomy. Assuming an attitude of professional distance is isolating, unfriendly and disengaged; it inhibits and suppresses an enormous resource in the human spirit. It is counter to holism, to integration, and to existential authenticity.

Relationship and emotional intimacy, trust and safety are closely intertwined and the moral imperative to promote good birthing requires real engagement with the pregnant and birthing woman and the emergent parents. Yet again then, the professional paradigm (Wilkins 2000) undermines the autonomy of the mother and of the midwife who, as an individual moral agent, wishes, through relationship, to empower, to nurture, to love, to midwife, the birthing woman.

How then do the midwives resolve this tension between, individual birthing and moral autonomy and professional ethical and contractual strictures? How do they (we) resolve the tension between gendered expectations which devalue caring as essentialist, and the desire and moral imperative to care, to love the women we attend? The answer is we live the tension, and we try to resolve them as best we can in the context of the relationships we have built. We are all too aware of our vulnerability and we attempt to manage the anxiety these dilemmas cause us (that indeed is emotion work). We live with the consequences of failing either the woman, or the profession, or both, in our attempt to compromise and resolve these tensions. There is no right or wrong answer we can derive from our professional codes, we must, and do, make our own personal ethical decision.

Midwifery, like birth is uncertain, but like the woman empowered to birth autonomously, we know we will survive whatever comes.

Ethics

The independent midwifery dilemmas outlined in chapter eight can be understood as dilemmas deriving from the disparate demands of midwives' personal ethics and professional ethics. As such they speak of ethics and ethical decision-making not just at the individual level but in the relationship between the mother and the midwife and between the midwife and her profession. In this section I would like to address also whether and how this ethical dimension of independent midwifery practice speaks to broader social concerns and broader societal ethics.

Foucault and Bauman have written extensively on the theme of ethics and their work may help structure this discussion.

Let me first consider Foucault. His writings have already features strongly in this study in relation to power and knowledge which he addresses in his earlier writings on medicine and madness and his later work on delinquency, punishment and incarceration. Foucault however, in his latest writings on sexuality and the care of the self, examined ethics, which he called 'forms of relation to oneself and to others' (Rabinow 1984:387). The key feature from Foucault's writing on the history of ethics is that, like truth, ethical codes are neither universal nor constant. He describes separately ethical codes and ethical behaviours making the perhaps obvious observation that they are not the same thing. Whether talking about ethical behaviours (acts) or ethical codes, he demonstrates that the subject, operation and intent of ethics differ radically between the ancient Greeks, Christians and enlightenment rationalists. What it meant (or means) to live a good life is very differently constructed in each of these (and other) ethical systems (see Rabinow 1984 but also Foucault's 'The History of Sexuality' parts I (1981), II (1987) and III (1990)). As is typical of Foucault, he does not propose an alternative political or ethical position, he merely points out the need to consider the changing discourses of what, from an ahistorical examination appear to be self-evident and hegemonic truths in our current society.

Bauman is not so reticent about displaying his political affiliations and his critique of contemporary culture. In his book 'Postmodern Ethics' (1993), he very clearly acknowledges the non-universality of truth and ethical systems. He considers that any corporate ethical system is to no small extent partial and with a more or less explicit political agenda. He argues that any social (heteronomous) moral or ethical code undermines individuals' ability to make personal decisions between right and wrong.

Taking a postmodern stance, a universal code of ethics is untenable. It seems then that like Foucault's genealogies, post-modern scepticism about grand narrative, and eagerness to deconstruct the constructions of modernity, leaves ethics without a universal truth upon which it might be based. Modernist notions of rationality and science may attempt to construct codes of ethics but Bauman argues that rationality cannot be applied to moral decisions.¹¹⁸ Bauman argues that there is no underlying explanatory framework for morality. Moral decisions are always ambivalent, and any action has potential for negative consequences for which one then bears the responsibility. Bauman argues that a post-modern perspective does not descend into do-whatever-you-like relativism but rather creates the possibility for a new morality which accepts the unknowable.

'Morality is not safe in the hands of reason, though this is exactly what spokesmen of reason promise. Reason cannot help the moral self without depriving the self of what makes the self moral: that unfounded, non-rational. Un-arguable, no-excuses-given and non-calculable urge to stretch towards the other, to caress, to be for, to live for, happen what may. (Bauman 1993:247)

Socially constructed moral and ethical codes, including medical ones and An Bord Altranais codes of professional conduct for nurses and midwives, have a purpose be it expediency or a contractual rationality, what Bauman calls 'a calculability of action' (1983:59). Whatever the comforts (or discomforts) of operating within a code of ethics

¹¹⁸ This same train of thought is found in feminist critiques of scientific rationality (Fox-Keller and Loningo 1996), and in a conception of science as an inappropriate basis for value judgements (Kuhn 1962, 1977 and Rorty 1982, 1998), See also chapters two, five and seven.

however 'being for the other'(1983:60), according to Bauman , cannot be regulated by codifiable rules.

Bauman's conception of personal ethical autonomy being undermined by heteronomous ethical codes such as professional codes, speaks very clearly then to the dilemmas independent midwives describe and the tension between their promotion of birthing autonomy and the constraints derived from their professional ethics.

This in turn offers a broader critique of contemporary society because as Bauman says:

'the morality/law dialectics presents itself as an 'existential predicament' of the human person; as an insoluble antimony of 'individual versus group' or 'individual versus society' type.' (Bauman 1983:29)

Independent midwives in their day- to-day praxis live this 'insoluble antimony' between meeting the needs of the individual woman and the demands of the group (their profession and obstetrics) or society which strives to control individuals, individual women and individual midwives.

This study demonstrates that commitment to a narrow and distancing definition of professionalism mutes the affective aspect of caring and 'being with', wrongly identifying instrumentality as the necessary aspect. This study has shown that human affection, that is, loving, is central to good, successful, autonomous birthing.

I am therefore tentatively hopeful for home birth and midwifery in Ireland; much is required to improve birthing autonomy, indeed we need first to recognise the degree to which birthing autonomy has been eroded in contemporary maternity service. The tenacity and determination, the skills, and the political will of these few midwives who provide home birth in Ireland gives me hope for a better future. I can only hope that the patent vulnerability of home birth and independent midwifery illuminated in this thesis serves to muster support rather than spell its final demise.

Epilogue

I tried, in the prologue, to capture the delight I experience when I attend a birth. I was a little concerned that perhaps it was a little bit over the top, mawkish and emotional. That is part of the reason why it appears as a prologue, outside the main body of an academic piece of research. I am chastened somewhat in re-reading this thesis to see that the concepts of professional distance and researcher objectivity are not only false and inadequate, but they are actively damaging to relationship.

I could not have carried out this study without building relationships with the midwives whose story I tell. I could not have sustained myself as researcher or as midwife without the extant and new relationships with midwives and others whom I count as friends. I feel fortunate to have been loved and to feel loved by my family, by Damian, my partner, and though convention discourages the word love, loved also by my friends and colleagues. My sense of security and sense of self come in no small part from this very fortunate background; it come from positive parenting.

I have watched others as they become parents, re-orientate their lives and focus on the things that really matter, their relationships and their hopes and dreams for their offspring. I know that how we birth is important for how we become parents and for how we will parent. I knew this from experience at the outset of this study. I now know how important it is for midwives (for me) to continue to advocate for good birth.

I spent most of my adult life avoiding politics because for me, growing up in Northern Ireland that meant, I thought, harbouring sectarianism. I have learned in the course of my independent midwifery work that keeping my head down is no longer an option for me.

I have watched independent midwives put themselves in very uncomfortable positions for the women they care for and for the ideal of a good birth. I have shared this discomfort of making difficult ethical decisions and I still feel the gnawing anxiety that should something unfortunate befall me, a mother or a baby in the course of the uncertain process that is birth, that my professional colleagues, my professional body or others' might use what is already a tragic circumstance, to promote its own status by being seen to 'deal with' an errant and unorthodox practitioner.

This fear does not help me to be a safer practitioner; it makes me less open, less generous, less loving.

The opposite of love is not hate; it is fear. ¹¹⁹

Midwives are called to love those who birth.
Parents are called to love their children.
Who we become, and what becomes of the world,
depends upon how we love, on how we relate.
The day to day of birthing and of midwifing speaks to wider society.
How we birth matters.

¹¹⁹ **1 John 4:18** There is no fear in love, but perfect love casts out fear; for fear has to do with punishment, and whoever fears has not reached perfection in love.

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Appendix One

Appendix One (Data sources for Audit)

Throughout the text supporting data sources are included in the following notation (page, line, source type, day month year) eg p37L29 FN 12Aug08

Source types are Diary - D
 Field Notes – FN
 Interview – Int

Where the data is not presented in the text and appears only in the code notation, the supporting text will appear in this appendix. Where the data code only is presented in this appendix, the full text has been presented in the thesis proper. Data is divided into chapters and is sequenced as presented in the thesis.

Where additional examples are offered that do not appear in the text, the code will be indicated in **block**.

Prologue

p5L22 FN 17Oct06 The midwife said a home birth was transformational for everyone involved.

p2L18 FN 27Sept06 Talked about being with a primigravida – more so than with multips. The wonderful thing about primis is the really far reaching consequences (how they view life and how they see the world) for them of a successful home birth. It changes their whole attitude to childbirth – it has a great effect, marvellous, wonderful experience for her (the woman).

Introduction

Chapter One **Situating Home Birth and Midwifery**

Chapter Two **Methodology**

p19L10 Diary 28Aug08 ‘The mothers’d be so up for it, they’re very keen to be involved in positive presentation of home birth’

Chapter three **Day to day**

Starting out
p9L34 Diary 28Aug06

Logistics
p2L25 FN 21Feb08.

p27L16 Int 21Apr08

p15L8 FN 21Oct07

p8L23 FN 11Jul08 Question – Do you take everyone that calls ? ‘No – distance is the first consideration. I try to keep it to the hour [travel time]

p2L17 FN 18Sept08 The midwife remarks on skyline saying ‘see how far the women have to travel along the peninsula on their way to hospital’

p13L36 Int 13Feb07 ‘you have to book your holidays in’ ie. create space for them by not booking women due in those weeks

p5L41 FN 20Nov 06 planning holidays more difficult – causing limitation of cases around holiday date

p6L4 FN 19Feb08 This year she is hoping to take off September October and November – to get a real break / holiday.

P22L29 FN 11Jul08 To be a IMW ‘you have to give up a lot’ ‘you need a relationship and partner support’ ‘it certainly curtails your social outings, you need a bit of a laissez faire attitude in life [to planning social life and holidays etc – that you can let it go] ‘you could burn out very easily, I saw that a lot, always being at people’s beck and call.’ Being overworked. ‘you have to try to be laidback.’

P5L16 FN 15Sept08 She zeros the car mileometer at the turn off closest to the village to be better able to judge where the house is in dark. ‘when it’s black dark’

p18L44 Int 17Aug06

p3L1 Int 20Jan08 ‘AN visits can take well over an hour, you’d rarely be out before the hour’ ‘And then sometime, when you’re just going out the door, they’ll say ‘will you have a cup of tea?’ and you know, you say ‘this is it’ and you have to stay because they’re ready to talk about whatever it is that’s been bothering them’

p6L22 FN 19Feb08 The midwife notices that one of the women we did not visit today lives in the same direction as we went today and a bit annoyed at herself for having to double back.

P13L2 FN 11Jul08 A midwife’s view on why so few midwives take up home birth practice: for midwives the practicalities of life come in to how we practice, how we work, the alternative [home birth] system is not supported and so people make pragmatic decisions. They want a regular job and hours, they know where they stand and they don’t want the on call.

A typical working week.

p4L25 FN 28Jun06 later I ask about decisions regarding post term management and she says it is very important that the parents are the one’s making the decision not her.

p1L11 FN 28Jun06 On way to first visit, the midwife tells me about a woman who has repeatedly refused anti-D after (?3) previous Rhesus positive children.

Chapter Four Relationships

Relationships with women

P20L20 Int 09 Dec 08 You know you'd meet 100s of women as a midwife and you know when there's something that doesn't click. Or it might be that you don't click with them, it might be something about their personality that it doesn't, you don't get it. I've never had it, I get on with most people but it might be just something where you think, no, this isn't going to work.

p6L12 FN 19Feb08 The midwife had a drawer full of birth and mother and baby photos. She was able to pick out and tell particular stories of several, probably all, the photos: a child born with very long cord and true not, she points it out in picture but difficult to see; sisters with very different birthing experiences, one easy and hard; women with very different birth experiences with subsequent children; some with serene and beautiful births; naked women with babies 'I can't put them up [on the wall] of course'

P6L10 FN 19Feb08 Change has to be asked for by women but that they need to be educated that there is more to birth than they are being offered in hospitals. That they have been made fearful of birth.

p4L19 FN 14Jun06 The midwife revealed her own lack of children [again as example of personal experience / history of birth not being an essential attribute of attendant at birth]

p4L18 FN 21Oct07 'In birth there's an incredible vulnerability'

p6L36 Diary 10Dec06 / Auto I spent some time talking about the new late booker (for me) Anne and my concerns about her blood conditions and not having access to her notes – that and her self medication willingness to forego GP visits in shared care. [this might be entirely down to her scepticism about medical people extending to scepticism about me and willingness to 'leave' as well as take my advice – feeling vulnerable to the possibility of her deciding to stay at home despite any concern I might have / what I might advise – I need to get over that – I can't be selling women's control over their bodies and their birth and at the same time being ambiguous about it]

p16L2 FN 21Oct07

p3L15 FN 15Sept07 A midwife talking of her daughter: 'she came with me to many births when she was little'. She also tells of how this was OK in [another country where she worked] and of a GP coming and seeing her [the midwife] with her baby son at her breast and woman on the floor delivering her baby, 'he was just fascinated'.

p6L13 Int 13Feb07

p13L14 Diary 11Oct07

p6L45 FN 17Oct06 her 4th baby, she has delivered all the others too

p3L8 FN 10May 06

p6L9 FN 29Sept08

p2L2 FN 04Dec08 Says that the relationship between midwives and mothers central – that they find a fit

p8L47 FN 18Sept08 'it's a two way thing, can I work with this couple or not ?

P46L5 Diary 18Apr06 The midwife talked about a 'doh see doh' in relation to how IMWs build relationship with the women in their care and how that a one off observation might miss the 'why' something was said in a particular way or was omitted to be dealt with later.

p4L34 Int 20Jan08

p15L22 Int 13Feb07

p2L18 FN 27Sept06

p6L32 FN 11Jul08 'I've changed a lot in that myself -not 'hardened' [as if reassuring herself of this that others / I might think so] it's about self protection in the end. Especially if you have two [births anticipated] at the same time. 'I feel I try to keep that professionalism rather than being overly familiar. They don't want that either. I'm not their 'friend' in that way. I keep it professional but friendly. I'm not invited to Christenings etc and I don't want to be., I do tend to meet them at eco things etc but the role is over 'cut out' [from the rest of her life?] 'friendly but professional. You need that if you are charging, being able to say this is my cost.'

p9L40 FN 07Jul06

p25L38 FN 20Nov06

p2L31 FN 29Sept08, Regarding a baby who had gone blue during and early breast feed. The midwife herself feels that the mother may have suffocated / smothered the baby perhaps against her skin breast but didn't feel she could / should say so to the mother. The midwife concluded there was no point doing that to the mother – giving her fret and worry when she has to be confident handling the baby The midwife said that if she said so the mother would be up all night for months worrying about the baby and blaming herself

p2L36 FN 07Jul07 The midwife says that the mother had told people, her and his family, too soon and that she (the midwife) could feel the worry and negative energy as the labour took a long time.

p5L22 FN 17Oct06 they were very anxious about home birth and about birth generally – the mother had had difficult births in hospital followed by C/S

p19L16 FN 20Nov06, 'you need to mind yourself going into that kind of situation' (one that will take a lot of emotional support) – particularly by having someone like a doula present to support the women in labour. – reference to 'pulling out of you' that both midwives talked of earlier.

p25L24 FN 20Nov06 'not a puller at all' [needy – wanting you to be with them all the time – no respite]

p26L11 FN 20Nov06 When I ask her later whether she thinks of that as 'pulling' she says no

p15L8 Int 18Sept08 The midwife spoke of some people / couples being very intense and demanding – takes a lot of emotional work and on several occasions she spoke of having to take time to reflect on the case (AN visit etc) afterwards (also but less emphasised to prepare before the next interaction) to consider the subtleties of it, options for care, and the effect of the interaction and relationship on herself. Time to unwind. The concept of work and life worlds impinging on each other is quite strong with this midwife.

p9L6 FN 20Nov06

p27L31 FN 20Nov06

p34L45 FN 20Nov06 One midwife tells stories about several late IUDs [intra uterine deaths], talked about awfulness of fishing around for the fetal heart

p20L40 FN 20Nov06 Of the second midwife 'usually in and out in a couple of hours' but in this case the husband was quite anxious and not a great support to the woman or to the first midwife so she called the second for support –the second midwife understands / understood this and was happy to be there for the first.

p2L16 FN 21Feb08 She acknowledges too that often feelings and intuition miss things or that worries turn out to be unfounded and all is well.

p9L18 FN 21Oct07 She feels that she needs a bit of space and time before and after each antenatal visit to prepare for or unwind after the session to get head space to be emotionally prepared or (self) debriefed. 'For example there are personal and professional issues.' 'It affects you if things are happening in your family and you are on call.'

p15L2 FN 21Oct07 Spoke of some people / couples being very intense and demanding that it takes a lot of emotional work and on several occasions spoke of having to take time to reflect on the case (AN visit etc) afterwards to consider the subtleties of it, options for care, and the effect of the interaction and relationship on herself. There is also, but less emphasised, an element of time to prepare herself before the next interaction. Time to unwind. The concept of work and life worlds impinging on each other is quite strong with this midwife.

p9L18 FN 21Oct07

p8L3 FN 11Jul08

Day to day relationships with others

Antipathy

p36L4 FN 20Nov06 midwives tell of GP and obstetric use of horror story anecdote to support their view of dangers of home birth

p2L15 FN 11Mar07 talked about previously having a good relationship with NMH. She had been asked to speak to student midwives about domiciliary midwifery. She had met with the Director and Assistant director of midwifery and the female consultant currently linked with the DOMINO and home birth scheme.

She had also been asked to speak to midwives when they (NMH) were first arranging to set up the home birth scheme. She talked about female obstetrician wanting to speak with her before she spoke to the midwives to make sure that she didn't say anything 'out of line'. She is not sure exactly what, but senses that the obstetrician wanted to control what she said, but as it turned out it was too late as she had already spoken to them.

So this midwife was known by the directors of midwifery and obstetrics. She was even shown around the delivery suite and was able to refer women for bloods and scans and to be with women who had been transferred in for hospital care in labour. But then there were difficulties and /or differences with other midwives (a midwife?) and the Dublin maternity hospitals withdrew services and that relationship was gone. The good working relationship was over. This 'being known', not a mysterious unknown person doing home births seems to be a key point. The NMH / maternity services knew this midwife and trusted and liked her.

p10L3 Diary 09Aug05 Today I got a reply from the master of one of the Dublin maternity hospitals regarding independent midwives relationship to hospitals and bloods and scans. The stance they continue to make is that there is no system of governance and regularisation of midwives and until there is they will continue to withhold those services. (It seems from the above conversation that they are indeed able to control that monopoly, unless some private means for obtaining bloods and scans can be arranged.)

p33L14 Int 05Jun07

p41L12 Int 05Jun07

p51 L1 Int 05Jun07

p51 L22 Int 05Jun07

p1L37 FN 20Nov06 Spoke of a particular female consultant on the committee who either didn't turn up or attempted to disrupt progress by harking continually at the issue of insurance. Obviously hostile and obstructive.

p12L14 FN 20nov06 A mother mentioned single visit to a hospital doctor. When asking about various things the doctor said that'll be Ok no problem but as soon as she announced she was having a home birth, he spent some considerable time talking about her history of small babies, her brother's depression history etc 'as if trying to make up a case for not having a home birth' She found it quite upsetting. Her husband confirms that that was the impression he got, that it was 'scaremongering'.

p28L26 FN 20nov06 A hospital consultant gave an invitation to GPs to come to visit the new hospital. He took the opportunity to make his negative stance towards home birth very evident, using statistics unfairly or inappropriately; but he was challenged on this from the floor by a senior midwife.

p7L16 FN 21Oct07 tells of a midwife who rang her in strict confidence to tell her that she [the independent midwife] was 'on a list' with a consultant in Cork who was talking

of 'pursuing' her as a result of her having assisted a woman to have a home birth VBAC. This scared the midwife and made her angry and she decided to write to the consultant about the particulars of that case [by way of trying to clear up the issue, but whether more to allay his or her fears I am not sure. She makes no further comment on what the response was if any]

She tells too of a willingness for some midwives too to berate her about things such as the timing of metabolic screening – 'it should have been on day X but you didn't do it until...'

p1L20 FN 04Dec08 This midwife felt she had had a good working relationship with several obstetricians up to that time [withdrawal of bloods and scans] and that they had been happy to scan or to review women for her, but then it was all closed down. She cannot be encouraged to see their response as anything other than protectionist and as competition for power and resources. She sees that they were being challenged as the sole determiners of birth practices / norms etc.

Liaison and communication

p2L41 FN 17Oct06 mentioned too that one of the midwives who had been on the home birth team in Sligo (while it existed) is now doing ultrasound scanning and has expressed a willingness to scan clients for her whenever she wants.

This midwife had described a particular obstetrician as being very supportive of the home birth scheme midwives when it was run from Sligo General Hospital and that he has recently suggested that they (he and she) might meet to discuss offering a home birth service again, but no details have been discussed between them.

p5L14 FN 17Oct06 talked about an obstetric consultant in James' hospital when it had a maternity unit. He did not take on a private practice and was very supportive of the midwives there. Says that when it closed down one midwife who had been a labour ward sister there took up independent midwifery practice.

p4L15 FN 28Jun06 The midwife and the woman talk about a term scan to confirm baby wellbeing and be able to make decisions what to do next. Term plus 10 days is quoted by the midwife as the likely time when hosp obstetricians usually decide to induce labour as that gives a bit of leeway to Term plus 14 days. The midwife asks the mother which consultant she is under and answer is whoever is on on a Wednesday. The midwife says oh dear, not the most helpful. The mother's friend, who is also there, expresses frank dislike for him making it clear he is not woman friendly. The midwife however knows the person in charge of antenatal clinic who would be quite amenable to arranging an ultrasound scan for her. (Later the midwife says of that obstetrician 'I've had my most monumental rows with him'.)

p34L6 FN20Nov06 talks of difference between reception by various obstetricians – with some as being supportive. She warns me not to deal with senior house officers (SHO's) because referral must be appropriate and SHOs are not appropriate as they are too junior and inexperienced. This compares to other midwives' advice to get to know the registrars as they are usually keen to get the problem solved rather than score points.

p2L6 FN 11Mar07 is critical of the obstetrician being the person who decides at booking whether a woman can be in the scheme or not. The inference being that midwives could be / should be making that decision.

p17L5 FN 21Oct07 talks of ‘pressure generally’ against home birth but not in [a named hospital]. She felt that [another named hospital] was more relaxed as maternity hospital than [a third named hospital], there ‘you could stand on your head’. When the mother says which GP practice she’s in, the midwife says ‘that practice is a fine practice, you’ll get your needs met there.’

p4L29 FN 27Jul07 a consultant who was positive and supportive of home birth and when it had been provided by hospital based midwives

P5L24 FN 11Jul08 I do subscribe to some hospital ideas (policies procedures etc) I like the idea of the 14 days check (post term ultrasound scan). [Named hospital] is better – if there is plenty of fluid then they are usually OK leaving woman for a couple of days. [Named hospital] has not such good rapport (the obstetrician there is respectful enough but is not for going beyond guidelines). [Named hospital] is more relaxed, more relaxed if the couple are seen to be taking responsibility for their decision.

p3L4 FN 15Sept08 Talks of an obstetrician who is absolutely gorgeous, some of the middle classes need the blessing of a Doctor, ‘then they have confidence in me’. Others will do it whatever people say / advise.

She describes how they (obstetricians) used to say ‘that one, that crazy woman, she’s got no training, we’ve had seven years in medical school. They described home birth women and their midwives as ‘those lame ducks’

There were two obstetrician and all the GPs were against me, in 1980 when I started ‘and they’d say, what you’re doing is really dangerous, we’ve come away from the stone age’

p4L4 FN 15Sept08 For many years she was invited back to the hospital to review meetings etc. but one consultant obstetrician seemed to direct all her talk towards the midwife who was seen to be challenging. ‘And it wasn’t just my paranoia, [another midwife] said she definitely did’. At some point they were just not invited back any more.

p2L44 FN 14Jun 06 stated that the threat that midwives are to obstetricians is not financial but an issue of control. They want to deny that home birth and independent midwifery is an acceptable option.

Hospital Midwives

p4L15 FN 28Jun06 The midwife knows the person in charge of the antenatal clinic who would be quite amenable to arranging an ultrasound scan for her client.

p1L17 FN 24Sept07 One mother doesn’t want to have to go to hospital at all and tells stories from other mothers and from her experience at antenatal classes about high levels of intervention and seeming disinterest on part of antenatal educators to accommodating non intervention, dismissing her with comments like ‘you’ll have to talk to the midwife about that when you come in.’

p3L2 Diary 13Oct06 Told tale of solicitor client whom had had blood pressure problems who’s GP was unhelpful about blood results and a hospital midwife who was similarly difficult when she contacted regarding the mother – ‘and who are you ? - she was very sniffy and rude.’

p7L16 FN 21Oct07 tells too of a willingness for some midwives too to berate her about things such as the timing of metabolic screening – ‘it should have been on day X but you didn’t do it until...’

p45L15 Diary 18Apr06 Talked about getting or having a relationship with the registrars in the maternity hospital – took me some time to unpick why registrars but it seems in her experience they're the ones who are daily making rapid serious decisions and unlike consultants or labour ward sisters are much less likely to spend valuable time asking why the independent midwife is ringing, or judging the independent midwife.

p5L8 Diary 03Oct06 Both parents were keen to talk about the baby and experience in hospital. They were very positive about their treatment. All went as they had hoped, a spontaneous vaginal delivery, no drugs, no tear. Baby Apgars were 9 and 9. They report though the tendency in hospital midwives for the language to be quite negative at times, 'just in case' 'if you get too tired' 'if baby gets tired or stressed' etc. They say they were constantly and repeatedly encouraging them to have ARM, oxytocin etc. That tell that they had to say no several times and also to syntometrine for third stage.

p3L26 FN 19Feb08 An independent midwife on hospital care: people are always coming and going, in and out during labour, different people for antenatal care, so home birth is a better option [relationship, continuity]

She has done a preceptorship refresher course in [named hospital], and she talks about the midwives in hospital losing skills, 'no wonder they're afraid of everything'

p4L10 Int 11Jul08 'There was a lack of recognition of home births even among the midwifery profession because it wasn't supported even by midwives. And still isn't in a lot of cases'

p11L15 FN 11Jul08 'Midwives can be just as problematic as doctors. They get medicalised by the system, more medicalised sometimes.'

p12L44 FN 11Jul08 I see a lot of oppression of midwives in general especially in hospital. This midwife shows an awareness of the medical model in funding and birth practices. 'Funding is directing practice, on the whole, funding [for birth] is within the acute hospital sector.'

General Practitioners (GPs)

p1L43 FN 28Jun06 describes all the GPs in her area as being very good. Three different practices, calm and supportive about bloods or anything else they are no problems whatsoever.

p10L10 FN 10May06 Two midwives have an arrangement with the local hospital laboratory whereby they can get anti-D at the same time as the blood sample is taken for testing and the result indicates it being needed and if the script is prewritten. This arrangement works well and requires blood bank and GP who are both supportive of this arrangement. [Conversations with my own GP, who has been advised by his insurers 'not to touch home birth', means he will not become involved with me in any aspect of care or professional liaison for women seeking homebirth.]

p1 L17 FN 14Jun06 talked about learning how to 'wangle your way' getting what you need without rows. 'Picking your battles', and it being 'easier to get forgiveness than permission'. When I told her about a doctor friend of mine's suggestion to email or write to GPs in the area about who might be supportive of home birth, her opinion was that that way I was more likely to be refused or attract difficulties.

p7L13 FN 30Nov06 The midwife telephones the woman's GP who is very supportive of women seeking home birth and of her [the midwife]. The midwife says however that the GP is always anxious about it and relieved to hear that women are delivered and all is

well. As the midwife tells story to the GP she acknowledges that it was ‘a bit of a pull’ but otherwise plays down the difficulty of the birth. [good independent midwife GP relationship, and an example of communication instigated by the independent midwife] **p7L23 FN 20Nov06** says that GPs in the area are anti home birth [I am not sure whether this was true before the neonatal deaths that have happened at home in the past four years] The midwife seems to know the names of certain GPs who are more accommodating and supportive of home birth and of her and her midwifery partner than others.

p15L26 FN 20Nov06 Talked about all the local GPs getting posted the home birth literature so they are or should be aware of the scheme and yet they hear of women who have been told there is no such thing as home birth in the area even those in the same village as the independent midwives. She spoke of a European woman then looking it up in the internet and finding one midwife so very close by that she couldn’t believe it. [It strikes me that such a scenario wouldn’t engender trust or confidence in the GP as unbiased broker.]

p1L17 FN 24Sept07 The woman’s GP and obstetrician have been unsupportive about home birth. They have refused care in that context. She doesn’t want to have to go to hospital at all and tells stories from other mothers and from her experience at antenatal classes about high levels of intervention and seeming disinterest on part of antenatal educators to accommodating non intervention, ‘you’ll have to talk to the midwife about that when you come in’. The midwife recommends that she put together a care plan and send it in to be kept with the hospital notes. Her thinking is that when the midwives see the care plan they will, between them, self select out those who would not be happy to accommodate a very physiological birth.

In meantime the woman has attended a doctor through her place of work for prescriptions for thrush. That GP though he says he is pro home birth is happy to tell of his own high personal intervention and C/S rate [in hospital practice elsewhere] and asks the mother whether she has had a full pelvic exam (to assess pelvic diameters/ size). She hasn’t but she says yes, but she allows him to do abdominal palpation.

p1L42 FN 24Sept07 In the midwife’s experience this GP position is not unusual. She has found only one GP supportive of HB. She feels it may be due to the MICS scheme (mother and Infant Care scheme), when they sign the women up for shared care, the duty or expectation of the GP to turn up for a domiciliary birth is mentioned and she feels that puts them off the idea at all and why they refuse to accept the women. She finds she has little dealings therefore with GPs and can manage to work

Public Health Nurses (PHNs)

p1L12 FN 27Jul07 Tells me also of PHNs ‘quietly’ doing home births in Donegal. One of her colleagues a PHN has been on call, probably 3rd on call, as she hasn’t yet attended a home birth

p2L35 Diary 13Oct06 A Donegal midwife doing her PhD who used to do home births from Letterkenny (I think) hospital introduced me to another who does home birth from the hospital now. She has two contracts with the hospital, one as a regular midwife and one as a community midwife. She has local PHNs who have midwifery registration as her second on call so she has support in labour. Only does about three a year because that’s what the demand is. She gave me her number and would be happy to talk to me. [She

strictly doesn't fall into my study as she is not independent but I could learn a lot from her or be able to quote as a workable alternative] An independent midwife was delighted to have got sitting beside her at dinner because she was excited too about that model as she seems a little disenchanted with her own arrangements.

p9L11 Diary 30Apr07 I returned a telephone call from a PHN who had met a mother I had been attending in her area. She was interested to hear about home birth and about a male midwife. She is teaching antenatal classes with Cuidiu (Irish Childbirth Trust) and wanted to know if I would be happy to be recommended for home birth by four Dublin based antenatal teachers – yes !

She says she is 'not so much for home birth per se but for women's choice'.

A good 10% people would say that they didn't realise home birth was an option or choice for them, and as long as they weren't 28+ weeks they could recommend it.

'I gather you didn't train in Ireland' [due to my being male or an independent?]

What women say is that they appreciate most the postnatal care, 'in some parts of west Dublin the PHNs are so busy that postnatal care may consist of one postnatal phone call and that's the total care they get in 18 months'

p1L16 Diary 03May07 I ring a PHN regarding planning for handover of care. During the conversation we talk about PHNs role in supervision. She says she has received no guidelines or instruction about the supervision or overseeing of independent midwives beyond receiving and noting intention to practice and ABA registration. (She has a similar role in relation to noting the heads of nursing homes.)

When I ask about a midwife seeking support or advice from her she says that is not part of her remit – though she has practiced as a midwife that is some considerable years ago. She is aware that there were a couple of domiciliary births in her previous area with no problems .

She reckoned it was a good idea, good practice, to try to make contact with the Dir PHN and PHN before the birth and maybe even to meet. But also to make a phone call after the birth before handing over care. Otherwise it can be an 'Oh God' reaction nearly keeping contact at arms length otherwise.

Very keen for me to get in contact again if another baby in her area.

Complementary therapists and therapies

p5L18 FN 14Jun06 The women the midwife has visited today seem to have a homoeopathist friend who prescribes for them. The midwife seems somewhat dismissive of homeopathy but keeps that quiet from women and yet she has also told me the tale of herbalist who cured broken vessels in her conjunctiva / sclera when all her own doctor would prescribe was long term cortisone drops which she would not like to be taking because of the side effects of long term use. It seems she is happy to recommend and or accept herbal remedies prescribed by this person.

p7L2 FN 30Nov06 advises calendula in shallow plastic pan (from delivery pack) that fits nicely onto toilet bowl [I think to compare this treatment to witch hazel which seemed to be preferred by the midwives in hospital where I worked in Northern Ireland] and whatever herbs suggested for same from herbalist (whose 'in labour' herbal preparations another woman had been using the previous night.) The midwife thinks highly of efficacy of the herbs.

p1L12 FN 20Nov06 One midwife shares offices with a chiropractor who is very popular and busy. She has recently concentrated or specialised in practice for / with pregnant women (and perhaps fertility issues also?). She and is happy to accept referrals from the midwife for mothers or babies. I gather especially babies at shorter notice due to their mutual connection.

p7L11 FN 20Nov06 The midwife recommends the couple organise their own antenatal preparation classes – suggesting a ‘Birthing from Within’ programme and local antenatal education / preparation classes. [At various times within these visits with these midwives, doulas and alternative therapists eg. Chiropractors, herbalists, homoeopaths and yoga teachers are recommended, suggested or confirmed to be suitable]

p1L7 FN 28Jun06 The mother shows a very septic, red swollen finger tip – which she would refuse antibiotics for and had tried knocking against something strongly to get whatever was in it, out. The midwife seemed to recall horseradish as a natural remedy and they looked it up (internet or herbalist text?). Together they considered a poultice of horseradish (with garlic) to draw out whatever toxins in the inflammation. The midwife was sensitive to the mother being very anti intervention – medical intervention and was then willing to seek alternative solutions with the women.

p3L15 FN 19Feb08 The midwife asks whether the woman has been using Rosa mosqueta on her nipples and perineum (rose hip oil) €9 for 20 mls, so expensive, but only use small amounts, use from 34 weeks to 37 weeks then stop. The mother started to use it late but the midwife felt it was better to use it even for a while - 36 weeks (?) now. She heard about it at a midwifery conference. It works well in her experience, softens and toughens the skin, the nipples don’t crack . She also recommends raspberry leaf tea and evening primrose oil 500 mg TDS. This midwife feels the combination is better than raspberry leaf tea alone as good for preventing prolonged pregnancy.

p1L36 FN 26Jun06 One midwife has a friend who is a ‘committed’ homeopath, who is willing to be phoned in the middle of the night and will even come out to the house unlike most others.

The midwife says ‘I blow hot and cold about it’. Regarding arnica for example, there is considerable variation in prescription. 30 TID or 200 x1 or x3 in first 24hrs. ‘or every time the cock crows on a new moon when the primroses are out !’ ‘But if she [the woman] believes it... it’s a comfort thing. I’m a healthy sceptic’

p3L42 FN 24Sept07 When I talk of having no alternative / complimentary medicine experience or skills to offer, but that I am happy with homeopathy because of the diluted beyond scientific / allopathic / pharmacological presence, this midwife tells of policies in New Zealand against black and blue cohosh which would seem to indicate that they (the medical establishment there) are sufficiently wary of it, or believe in its effects, to have a policy against it.

Day to day relationships between independent midwives

p2L7 Int 20Jan08 One midwife about another midwife facing ABA fitness to practice investigation: 'She got no support from midwifery, she got support from the mothers.'

p46L34 Diary 18Apr06 'it will always be like that (frightening) you will always feel isolated'

p7L10 FN 15Sept08 Tells a VBAC story: her supervisor PHN was advising her not to go out to [the mother] and she was finding that professional isolation very stressful.

'There's all that hassle and scaremongering [from GPs, obstetricians and PHNs] 'I have something on me that just switches off'

p46L9 Diary 18Apr06 Contrasted Ireland with the UK on several occasions with home birth and independent midwifery here being particularly sensitive / vulnerable to criticism and attack. If she had concerns with an case on an ongoing [antenatal?] basis, she would ring her midwifery contacts in the UK to discuss it, rather than other independent midwives in Ireland because she already has those links

p2L34 FN11Mar07

p10L10 Int 17Aug06

Q Ok, so you decided that it wasn't Ok for you to go to work in a maternity hospital. You had then other choices to make.

A Yeah. I knew that I couldn't come into the hospital system because I have friends here who are midwives here and just listening them I just know it wouldn't have been for me at all. You know whereby I was coming from a system where I was delivering women in alternative positions and I was suturing, I was suturing and I just knew that I'd be up against it really.

Q Up against ?

A I'd be up against. I'd just be up against it for myself. I felt I just lose the autonomy that I'd had that all that I'd learned that I'd become deskilled very quickly and I was determined there was no way I was going to lose what I had in terms of what I loved you know. I just thought there's nothing for it, I felt I was backed into a corner then and there was nothing for it but to strike out on my own. And I knew I had the wherewithal and I knew I had the skills but I knew as well that I was coming into a culture where I'd be seen as a fruitcake.

Burnout

p6L2 Diary 14Nov07 One midwife says: People / partners / families aren't willing any more for the on call, and disruption that that causes. 'Partners get sick of it.'

p5L41 Diary 14Nov07 The same midwife also spoke of New Zealand where the midwives are paid by case, and end up overworking in order to improve their salary. She warns that this is a danger of payment per case. She cites Waterford scheme where there is an on call rota, first and second on call, as being sustainable and well supported.

p4L28 Diary 07Jun07 Of independent midwifery 'I don't see it as a sustainable model'

Collegial support

p16L18 18Sept08 But the understanding with midwives doing home births is following what's working in birth. And the process, so if you have a fundamental belief in that, that women are well designed and provided that they look after themselves and that, you could never really know, but it's more likely that the baby is going to come down and out

than any other scenario, although that could happen. Then, it's that that's shared between midwives who do home births, and that's where you get your confidence, because you're building from that point. And when things don't go that way, that's when you, that's where the sharing between independent midwives can be crucial and you can reflect on.

p4L23 FN21oct07 'Isn't it well documented that midwives from whatever setting or country get on well together?' 'for instance my mother rang today and a student midwife from London wants to come to speak with me and I'm on call and I have no reservations about meeting 'cos there's this thing between me and her, a midwife, 'cos she wants to communicate so we'll get on.'

Is there a relationship, a sense of community between independent midwives ?

Yes there is a commonality. 'We are all independent natured, if you didn't get on it didn't matter, you'd find one you did.' 'In Ireland you need to get through the preliminaries, barriers, even the suspicion. There are some who will share and some who won't.' 'You can tell immediately. Instead of sharing you get judgement.'

p4L22Diary 07Jun07 'I don't see it as a sustainable model'

p5L2 Diary 14Nov07 People / partners / families aren't willing any more – for the on call and disruption that that causes. 'Partners get sick of it.'

p4L26 Diary 14Nov07 Re Albany – a good model but lacks sustainability. She compares the pattern to independent midwifery with nine months on and three off.

p4L41 Diary 14Nov07 also spoke of New Zealand where the midwives are paid by case and end up overworking in order to improve their salary – that this is a danger of payment per case.

p4L44 Diary 14Nov07 Cites Waterford scheme where there is an on call rota first and second on call as being sustainable and well supported.

p1L12 FN 08May07 During an interview / conversation with two midwives who work together: The older had been an independent midwife doing home birth for many years without any support before the second midwife came along. She says she is very glad to have the other working with her. The younger is delighted to have the first as support, and says perhaps would not have gone into it without her and the Cork HSE scheme arrangements in place. They, like another pair are at pains to say that although their work is integrated with the HSE, they are not well integrated with the hospital structures. The independent midwives and the home birth scheme are dependent on a positive response from hospital obstetricians which is sometimes there but often not. They cite two obstetricians one supportive one not in the same hospital.

p12L10 FN 20Nov06 During postnatal check the midwife mentions the woman had a previous 3rd degree tear and needed some stitches this time. The midwife says she was delighted to have an experienced second midwife available (she arrived just after delivery) to check the perineum and confirm that the suturing looked OK.

p6L12 FN21Oct07 'Independent midwives need to be able to handle complaints personally – which takes time and courage. Peers [discussion with colleagues] ought to help.' 'Sometimes I go to England for that support.'

p6L12 FN 30Nov06 The next morning the midwife tells me that she has rung her colleague to talk with her about the birth to further debrief. She uses the word debrief, she says she talks through and shares things with her partner midwife that she wouldn't say to others. She says she wouldn't go back to days prior to having a partner – that having that support helps to avoid burnout. (She reckons she was close to burn out at the point that

the other midwife came to join her seven years previously. In London she had been in a group practice of 24, three teams of eight in pairs who shared work with GPs and clinic. They had which provided her with an element of sharing and support.

p9L8 FN 20Nov06 She reports that midwife partner would often say to her to mind herself, that having a partner has been a great support to her. It helps her to keep things in perspective and that she probably was a lot closer to burn out before her partner came than she ever thought.

p18L5 FN 20Nov06 this security of having a second opinion a constant theme

p5L31 FN 29Sept 08 very positive about the steering group peer review meetings. Feels that there is a good opportunity, if people want to take it, to talk about difficult cases and management decisions.

p17L6 Diary 26Oct07 One midwife still feels we need an association and that then the rest of us can answer collectively. But another midwife has consistently blanked this idea in the past.

p5L6 FN 19Feb08 I had no choice – when I say she must have had choice to work in hospitals, she said she just couldn't, that [where she trained] was even worse for sitting round watching monitors rather than being with women.

p16L6 Int 18Sept08 'I think sometimes we don't say how we feel or we don't say how we, the truth about either our experience or our failings or, and it's taking a risk to feel strong enough about what we do to say, well actually, I screwed up on this or, I think that's a big thing in independent midwifery, you've got to be able to talk to somebody about things that you weren't happy with, about your practise, rather than this bravado that, all independent midwives are absolutely brilliant and terribly experienced and, I don't know how useful that is.

p15L24 Int 11Jul08

Q What supportive roles do midwives have? Where do ordinary midwives get their support?

A They get support from their union as regards but that's mostly as regards their income, salary and their job description.

Q What about professional decisions?

A Professional decisions they really have, if it boils down to it they really don't have, we are supposed to get them from the Department of Health and Children midwife advisor but its quite vague and sometimes you don't know who, I don't think there would be that many midwives in the country that would have a name to say well I'll ring that person's department because I want professional advise and I want support. There isn't really anyone clearly identifiable there.

Q If you are in hospital you can go to the senior managers there.

A Yeah they do look to Bord Altranais for that but if they knew you know a nurse they would know that's not the role of the Bord Altranais. Its in the public's interest.

Q So if you were, independent midwives where do you get your professional support?

A We get it, we don't get much professional support but we would get it from within our own profession, our own independent group which is very small and most of us really haven't met each other, we've met a few and I'd be meeting people through like yourself and others through meetings. But I would be much more

inclined to ring someone like you or you know XXXX or someone, I'd keep it within the small group initially, I wouldn't go to a hospital midwife. I'm lucky in my colleagues at the university there would be some professional there, I'd find them very supportive. But really there is very little support for a professional view point if something was really concerning you. they'll say, I'd more than likely get from the hospital - I told you, you know you are out there on your own you are bound to come a cropper one of the days. It wouldn't be unsupportive but it would be that kind of attitude, I've heard that being said. You know its not good to be working alone like that, its actually you are setting yourself up for some kind of problems.

Q So everybody is saying it's a bad thing to work on your own?

A Yes, yes.

Q Yet what choice do you have?

A There are no options if you want to do it, there are no choices. And the women then would have no choice. The women are always saying that you know it is very, very hard to know that there's only one midwife in a whole region that can do the home birth, and she may not be able to do it. But there is no real professional support even for the midwifery professionals in the hospital its sometimes hard to know who to approach to get that kind of professional support at a higher level. Like I say they do look to professional bodies a lot of the time but when it comes down to it they can give you an opinion but is that support?

Q Not really.

A Its not really so when it comes to the crunch and if it came to really down to the wire you realise your professional body is more in the interest of discipline and seeing that your practice is up to the standard or below the level of expected practice or whatever.

Chapter Five **Discourses**
Pervasive discourses

Muted Discourses: Intuition and Spirituality

p23L4 Int 09Dec08 ‘It’s kind of, it is because it’s really magical. I don’t know the, each birth that I’ve ever been to is like, it’s so different, everyone is so different. You might see similarities you know but it’s just like when that baby is in the mums arms and that moment when they get to meet the baby that moment is like, that is spiritual, that in itself.

p34L20 Int 11Jul08

Q **So you’re describing your understanding of the spirituality of the event, but its not something you bring up with the mummies, it’s not something you talk about?**

A Never, never bring it up.

Q **Do the women bring it up**

A They might say oh it was a really great experience, I don’t hear any women saying it was, the odd one might relate it to a spiritual experience but that would be seldom mentioned at all

Q **And rarely antenatal or never antenatal.**

A Never, never you don’t talk about that at all, they just talk about having more control in their own, they’d like you know some of them would say I just want me and my husband.

Q **Is it because its socially acceptable to be pragmatic and say I want this and this, is it unacceptable to talk about the magical mystery of birth, or is it a wee bit too?**

A Not a very Irish thing to do.

Q **I think not.**

A No, no, it isn’t.

p35L14 Int 11Jul08 Most people are very ordinary, they don’t go into the spirituality of it.

P36L18 Int 11Jul08

A Yeah they very rarely talk about the spirituality of it so even if I were writing myself I wouldn’t go into great detail about that even though you feel that, I think that’s because Irish people are quite, they are on the whole if they went back to their true self they are quite spiritual. They have a sense of it.

Q **Why don’t they talk about it?**

A We don’t talk about it because it seems normal.

Q **You think?**

A I don’t know.

Q **Its normal so therefore we don’t have to talk about it?**

A Yeah, I don’t know.

Q **Maybe, it could be.**

A They are quite, you can see it in the way people often are with funerals and things like that. I do see that, having lived in another culture I can see that they are quite spiritual a lot of them, if they let themselves go back a bit to what they really are. They have an understanding of that.

Q And yet there's something that keeps it below the surface.

A Yes there is.

Q Its not something we share or talk about.

A No, because a lot of us have been indoctrinated into religion and into Catholicism and they are trying to break away a lot of them from that, there would be a bit of confusion between spirituality and religion.

p4L13 FN 15Sept08 'a woman is never the same after birth, she's changed, something deeper than she's ever been, has been at the bottom and come all the way up has had an experience like death and resurrection.' 'the women really know themselves and are delighted after the birth, know they can face anything no matter how bad.' 'it's [birth is] just bloody hell, down in the depths, like the dark night of the soul' 'it's the single most amazing thing a woman can do'

p1L19 Int 20Jan08 'I don't know about the evidence, it's intuitive, but I feel that it twenty or thirty years time there'll be evidence and I'll be right that things are better left on their own that nature should be left to it.'

p29L17 Int 21Feb08 'you know where the babies didn't have any will to live, they didn't come around'.

Intuition

p2L1 FN 21Feb08 She spoke too of the spiritual side of midwifery of birth that 'of course people don't talk about it' but that that doesn't mean that its not there.

Speaks of sometimes doing a palpation and being unable to describe what exactly she is feeling but that has a feeling there is something intuitive about whether the baby in the right position or if there is a problem Not something that you can write down, not something that will be understood in the present way of thinking so not talked about but that there is certainly something in the human interaction the knowing the woman the wealth of practical and personal experience that brings more to and draws more out of the interaction than can be easily explained.

p9L3 Int 13Feb07 describes herself as a cautious person and says she goes by instinct if she is not happy with things she has to feel that the woman will understand and transfer to hospital even if its mostly 'instinct' 'I would rather she was annoyed at me and they were both well than'

She says 'I've been blessed, I've been very lucky' not to have had any bad experiences [later she does suggest that there have been difficult incidents but the nature of these was not expanded upon and she does not mention any intrauterine or neonatal deaths]

p34L45 FN 20Nov06 Advises me to trust my instincts of not knowing and to transfer if worried.

p4L4 Int 19Feb08 Talks further about intuition 'she's not going to make it [labour successfully at home], I know'

p2L16 FN 21Feb08 Tells story of woman only 7 or 8 days over her dates that the midwife was attending. She was not in labour and not at a stage in pregnancy when the midwife would be concerned but she felt something wasn't quite right at palpation, or about her history, or the woman or the baby – 'nothing documentable' or clear but the midwife transferred her to hospital care. The baby turned out to have a significant cardiac blood vessel transposition which was incompatible with life. The midwife was very

relieved that she had decided to transfer for investigation . She acknowledges too that often feelings and intuition miss things or that worries turn out to be unfounded and all is well.

p7L29 FN 29Sept08 One midwife argues that feeling' (of the midwife or GP or obstetrician) is not good enough reason for disregarding best evidence. Indeed variance in 'feeling' is the very the reason for applying evidence standards criteria.

Spirituality

p4L40 FN 18Sept08 'its about acknowledging something greater than us'

p7L37 FN 11Jul08 but home birth is my first love, birth outside the hospital where women have more choice and support and for the spiritual experience it is for me.'

'A spiritual experience is achievable at home – midwives in hospital can't seem to make it work. I mean hospital; is great if you need it, but it's not a normal birthing environment.'

p8L45 FN 15Sept08 'I've got great faith, I've got the divine physician. Doctors are only a rubber stamp.' 'If mother is well and baby is well' 'the baby doesn't have the rule book'

p1L45 FN 21Sept08 'I have a strong spirituality and I don't doubt it.'

p5L42 FN 18Sept08 'I'm feeling very alone, I'm at this place and I can't reverse, so I sit here, I have to trust, there's no reason to suppose that there is a problem'

p5L19 FN 18Sept08 'I'm fated to be at this birth, sent for a reason'

p5L21 FN 18Sept08 'Both [parents] were very grateful for this 'allowing' of the birth' 'it was fate, I was a player in the drama, if I had behaved in any other way there would have been a melodrama, there was an acceptance that goes beyond professionalism'

p13L15 Int 13Feb07 She definitely seems to view the womb as a sacred place. She refers to a magazine article she read about a family who decided they were going to put their US scan pictures away in the attic because they felt that the US scan was an intrusion into the world of their baby. She felt some sympathy with this view. [– see theory earlier about babies not liking it.] 'Scans are great if you need them but they're not for entertainment purposes'.

p22L25 Int 09Dec08 And it is a sacred space and it is creating that to the point where they feel safe. There's no intrusion. Its quiet, most of the births that I go to its very, very quiet, I might not need to say a lot. I do talk a lot generally but at a birth I'd be really quiet, I'd whisper you know.

p5L13 FN 18Sept08 The midwife describes this case as 'protecting that space' and that despite her own extreme anxiety and the difficulty of the relationship and the isolation and the indications from the guidelines for transfer etc that she had come to an inner calmness and acceptance of her situation, 'I'd surrendered all, that crap, the trying to do it right for the scheme, going against what the other midwives might have done' ' I could have bullied her' 'it's in the lap of the Gods, what will be will be' 'I'm thinking of another midwife [an independent midwife in a professional practice hearing over NND at birth] , I'm fated to be at this birth, sent for a reason' 'all I could do was hold that space for her. I think that's spiritual, not the doing, but the being, the NOT doing.' 'Both were very grateful for this 'allowing' of the birth' 'it was fate, I was a player in the drama, if I had behaved in any other way there would have been a melodrama, there was an acceptance that goes beyond professionalism'

p8L2 FN 11Jul08 Women experience it as a spiritual thing – even if they have had a hard labour – they wouldn't talk about it as spiritual (and neither would I bring it up antenatally, for example) and it's not tied up with religion, it does appear to be spiritual [But more than once, and again in interview next day this midwife is keen to separate spirituality from religion]

p37L6 Int 11Jul08 'a lot of us have been indoctrinated into religion and into Catholicism and they are trying to break away a lot of them from that, there would be a bit of confusion between spirituality and religion.'

P31L18 Int 11Jul08 Everything is nice and quiet and they generally have a few things around them that are quite spiritual, not religious but some of them would be a bit religious too. It's a different feeling, its just the woman and her baby and her family just there and they are all very earthy and you know you think it is a real earthy or spiritual experience. It feels it. It feels it, its not to say now that someone who's had a hard enough time in labour can be very tired but there is, its just then it's a new baby and it feels very spiritual I think. Its hard to define it other than it's a very important occasion.

p4L6 FN 18Sept08 The midwife speaks of 'the baby coming into itself, people say the baby 'comes in'' tells story of a baby that at three days old that both she and the mother could detect a distinct change in the baby, 'until then it didn't seem to be 'present', it lacked a zest for life, some [indefinable] other or extra dimension'

She acknowledges the native American Indians as having rituals for calling the spirits that seem to her to strike the right note, capture this 'coming in'

'some people might say 'ensoulment', it's the sort of thing that you hear midwives talking about midwife to midwife' [but not generally widely or to other professionals, why ?]

p13L1 Int 13Feb07 The midwife says she is a Catholic but not particularly religious. Believes in God and when on her own and when things a little difficult say at a delivery she gets some comfort from feeling that she's not alone. She doesn't raise the subject with women she's looking after but says that sometimes at delivery or just after the woman may refer to something spiritual about birth or birthing. She describes birth and the baby, the perfection of it as being a 'wonder' – uses the concept of wonderment to refer to / describe the spirituality of birth. She describes birth for the baby being something like death for us (adults) in that the baby moves out from the only world that it knows into a completely different existence – likening our death as a moving out from this world to 'hopefully' another world, life, existence.

p3L50 FN 11Jul08 'some women come back and talk about a spiritual birth experience'
p2L1 FN 21Feb08

p3L39 FN18Sept08 The midwife asks her mothers to make their own notes during pregnancy and after birth about their experiences feelings thoughts etc, 'to reflect on their own birth story, the important transformation into new parenthood' but BEFORE they see what she herself has written about the birth in the notes, because then she feels she is implanting a version a perspective on it that was not their own. 'That would bring in MY views [or spirituality] and I don't want to impose that.' 'It's often not discussed, if you put it into words its *your* words not theirs'

p4L16 FN18Sept08 I ask about MW role in the spiritual sacred etc.

‘if there is such a role, my role is in allowing the birth to take place, [creating , protecting preserving that birth space] not just being aware of maternal positions or the use of gravity, or avoiding over stimulation’

p5L39 FN 18Sept08 Tells the story of a woman well advanced in labour, I’m there about twenty minutes and haven’t had an appropriate time to listen to the fetal heart and I started getting nervous [about that], a bit defensive because of the [midwife fitness to practice] situation, and I’m feeling very alone, I’m at this place and I can’t reverse, so I sit here, I have to trust, there’s no reason to suppose that there is a problem, I’m sure the baby would have told me if it wasn’t ok.’ [I talk about that particular quote and how that if taken out of context it would sound bizarre or unacceptable. She acknowledges this – and I feel she trusts that I won’t do that, I do understand what she means – what do I understand ? is this unprofessional ? is this with woman ? is this appropriate ? I believe so ? why ? indefensible ? defensible to whom and by whom ?]

p4L6 FN 18Sept08 The midwife speaks of ‘the baby coming into itself, people say the baby ‘comes in’’ tells story of a baby that at three days old that both she and the mother could detect a distinct change in the baby, ‘it didn’t seem to be ‘present’, it lacked a zest for life, some [indefinable] other or extra dimension’

p4L29 FN 18Sept08 ‘we light candles for a birth’ ‘In [antenatal] classes, if people are in agreement, when we hear that someone in the class has gone into labour we light a big candle for them, and leave it lit until we hear that the baby has been born’ ‘it’s a lovely thing because then women know there are other women thinking of them wishing them well, have them in their thoughts and supporting them’ [avoids the word praying for them but that is the sense I get from her telling. I ask is that derived from a Catholic lighting candles thing? She says no] ‘Ireland always used to light a candle in the window for a birth’ ‘a candle of intention, the intention is in the flame’

Chapter Six On Autonomy

Autonomy rhetoric

p6L32 FN 21Oct07

p5L42 FN 21Oct07

p2L32 FN 07Jul07 The midwife had said that she found the woman to be very quiet and timid, quite shy, and so a little difficult to chat with communicate with. She finds it difficult to know what to say to her. The midwife talked though about the woman in birth who was very strong and self reliant talked about her being like a tiger – a completely different woman. The woman new exactly what she wanted in labour and didn't much want the husband about her, he OK with this and happy to do crossword in next room. The midwife talked of the woman's strong inner resources and her professional / business skills in other settings

p2L25 FN 21Feb08

p6L9 FN 29Sept08

p8L47 FN 18Sept08

p12L29 FN 20Nov06

p2L9 FN 21Oct07

p2L43 FN 21Oct07

p4L18 FN 21Oct07

p6L34 FN 21Oct07

p22L33 FN 20Nov06

p4L25 FN 28Jun06

'Being with' in Action (Aspects not supported directly in the text)

Presence, availability, warmth, leaving time, giving space

p2 L3 FN 07Jul06 This has all taken about 5 -10 minutes and while the midwife has spoken with the mother, asked her how she's coping and is able to see her walking, stopping and breathing with contractions, it is only now that the midwife starts to take formal clinical observations, BP and temperature, pulse, fetal heart rate by Doppler and urinalysis. No abdominal palpation and no vaginal examination.

p2 L26 FN 07Jul06 The woman is walking throughout and withdraws to the adjoining utility room and leans on window sill or work top during contractions breathing in a deep slow controlled fashion. At this stage the midwife allows / leaves this distance but later in the labour goes with / follows her in and out to the utility room. The midwife says very little to the mother, only occasionally and very softly during contractions, 'well done', well done[name]' and 'you're doing fine'. [I wonder whether this withdrawal is a general withdrawal from the company or perhaps from me but I definitely feel that I should not follow the woman, and midwife if she's with her, into that room at this stage. The door is still open and I can observe and listen easily without overtly doing so.]

p3L10 FN 28Jun06 Much of talk between midwife and woman seems to be about house building, slates etc. The woman and her partner are living in mobile home with a kitchen attached on a plot on their father's land. The talk is not apparently midwifery in nature. Again the visit takes about an hour and the midwife says that that's usually how long it tends to take. It gives the woman time to feel comfortable and address any issues / ask any questions she might want to.

p20L4 FN 20Nov06 The midwife is initially fairly warm open to the idea but as she heard more details and examined the mother's perceptions of how she might be post delivery and whether willing to stay in the neighbour's house if not in form for the move to her own home etc – the mother came more to the idea of hiring / buying a pool for their own house although it is small.

p1L10 FN 18Sept08 Gave time and openings to say what was on their minds each time asking how they were, how they feel and what they want to cover in the session. Answering any questions and suggesting things to cover.

p12L35 FN 20Nov06 The midwife described that visit as being mostly social – that social element – just being available for women for them to ask questions

Time, Silence, listening, asking,

p1L27 FN 07Jul06 asks where to set up her things and the woman indicates a double bedroom on the ground floor closest to the kitchen which has a bathroom en suite.

p3L25 FN 07Jul06 asks whether she might do a vaginal examination to check progress.

p3L34 FN 07Jul06 asks 'is the TENS making you shaky?' but the mother replies 'no'

p3L19 FN 07Jul06 Mostly quiet, very little chat

p4L10 FN 14Jun06 The midwife seemed careful to check how the mother was reacting to her explanation of why a 'sweep' was not feasible.

p1L25 FN 17Oct06 The woman is concerned that she's very big (fundus does seem umbilicus +) and heavy in the pelvis. The midwife listens but doesn't comment.

P2L38 FN 07Jul06 At 4:15 the midwife asks whether the mother feeling any more pressure during the contractions. 'not really'. I am not sure at this stage why the midwife asked but later when I can hear a change in the mother's tone, a hint of glottal stopping or possible bearing down as she moans with the contractions. The midwife asks again and the reason why seems very clear to me, perhaps earlier she had heard a change in the mother's tone or body language.

p12L29 FN 20Nov06 The midwife feels this good as gets women chance to debrief ask questions and settle into parenthood. One of the things the midwife says she enjoys is the whole transition from early pregnancy, through labour to becoming a parent. She describes 'it's like a circle' the holism and continuity element of domiciliary midwifery.

p3L29 FN 19Feb08 The midwife seems quite happy to sit for a few minutes in silence while the woman and her partner sit, waiting for them to speak, to articulate their needs, concerns, questions.

Respect, permission, responding & anticipating

p3L29 FN 07Jul06 The midwife gives explicit permission to make noise during the contractions, to let it out and not close over her throat, not to hold it in her throat and she does gently at first, I also notice the midwife is beginning to rock or sway during the contractions. At this point when tone changes the midwife suggests that the mother huff to delay pushing but that she can push if she feels like it.

p9L34 FN 10May06 None of this regarded as unusual or treated with anything other than respectful listening by the midwife.

p1L11 FN 28Jun06 The midwife seems sensitive to the woman being very anti intervention – medical intervention and is willing to seek alternative solutions with the women.

p9L22 FN 20Nov06 The woman's breasts are engorged and she is having difficulty latching baby on. The midwife listens and advises, she helps to express some milk. She advises the mother about hand expression and helps latch the baby to the breast.

p38L10 FN 20Nov06 first words of direct encouragement to the mother [some considerable time in to labour]

p38L15 FN 20Nov06 'if you want hands off or it doesn't help just tell me'

p12L26 FN 21Oct07 encouraged them to tell their stories.

p12L35 FN 21Oct07 rather than jump straight in with advice the midwife tried to draw from other mothers' experiences, to get them to share ideas and find their own solutions.

p5L11 FN 15Sept08 The midwife called each mother as she was leaving the previous one, announcing that she was going to arrive or to give ETA (estimated time of arrival).

Information, choices, explanation.

p4L13 FN 07Jul06 The midwife had to get a capillary sample from the baby which involved having to explain to the mother what had happened and why she was having to prick the newborn.

p4L22 FN 07Jul06 At 12:16 we leave the house. The midwife leaves instructions to the mother to pass urine and to have paracetamol for afterpains. She explains that as the baby has now fed well it will be OK for the next 24 hours. She checks the mother has her mobile number and to call if she has any worries. She explains that vaginal blood loss is usual and quite heavy period loss is to be expected for the first few days. She says she will come to see tomorrow about anti-D and for a postnatal check.

p3L17 FN 10May06 With each mother the midwife told the woman the result of the blood pressure reading. Assuring that it was normal and comparing it to previous readings, whether at home or in hospital. When she noted that one woman's blood pressure less than in hospital she said 'sure that's no wonder'.

Engagement in and ownership / responsibility for decisions

p3L9FN 10May06 The mother held the urine testing strip to the bottle reference strip and they read result together noting the only remarkable colour change was the pH.

p16L14 FN 21Oct07 'some [women] just test it themselves'

p29L19 FN20Nov06 [When in labour and the midwife is considering transfer to hospitals] she tends to create thinking space early for parents, - sowing the seed [that transfer might be necessary]

p2L28 FN 24Apr07 The mother seems to perform vaginal self examination in pool noting a soft bulgy thing (fore waters).

p5L11 FN 24Apr07 The woman is keen to avoid sutures even if there is a tear, and is keen to see the grazes and tries to use mirror to see them.

P4L45 FN 24Apr07 The midwife talked through her thought processes with the mother.

p10L15 FN 21Oct07 'But even in deciding to transfer, they were making the decisions all the way'

p5L5 FN 24Apr07 Do you think you know enough about vitamin K to make a decision? She repeats the explanation again as the mother asks, and says ‘even with all the evidence it is not conclusive’.

Countering dependence or abdication of responsibility

p3L6 FN 28Jun06 The woman tells she has spent day previously, or some of, pulling ragweed from her father’s field. She has a history of a ‘dodgy’ back and seems to expect the midwife to scold her about this but the midwife seems fairly sanguine and say she reckons that women can do whatever they feel able for.

p4L25 FN 28Jun06 The mother says ‘whatever you think’, and the midwife says ‘I can’t tell you, you decide’

p9L28 FN 21Oct07 The partner’s advice had been to ‘just shout at her’ [the mother] ‘make her’

p3L19 FN 15Sept08 some of the middle classes need the blessing of a doctor – ‘then they have confidence in me’

Promotion of social and personal resources, practically and preparative of woman’s self belief / confidence

p7L35 FN 10May06 She brings with her a book (don’t remember title) and collects another she has left with her. She has a series of seven books she brings to women and rotates from visit to visit [I need to get book list – one is Leboyer ‘Birth without Violence’. It strikes me that this practice brings with it a value for money element to the paying relationship with the women but also serves to get them into the mindset for pregnancy and birth perhaps also to prepare them for both. She also brings, towards the last visits, a women’s story book with photos and birth stories written by women she has delivered over the past [eleven I think] years as an independent in Ireland. Her clients all hold their own notes – an arrangement that she grew familiar with in England.

p15L24 FN 21Oct07 The midwife brings out from a small store room, a labyrinth hand made of red clay on a circular cake base approx 30 cm x 30cm, a little dusty. She asks the mother if she did this with her last time, she thinks no. The midwife explains it is a tool for thinking about how the birth might go. Explains that the mother, with eyes closed, will trace course of the labyrinth as she guides her through a possible story of the birth. The mother is to visualise how she feels and how she will cope with the scenes in the visualisation.

p15L43 FN 21Oct07 The mother seems very clam and ready for the birth and the possibilities and also very open to this kind of exercise. [Likening coping in labour with finding your way through a maze seemed to fit very well, the mental visualisation linking the physical digital search paralleling the physical experience and the cognitive coping.]

The costs of being available and declining

p9L6 FN 20Nov06

p8L3 FN 11Jul08

p7L18 FN 20Nov06

p17L27 FN 20Nov06

p4L25 FN 17Oct06

p1L43FN 27Jul07
p7L32 FN 29Sept08
p5L13 FN 24Sept07
p8L40 FN 21Sept08

Appropriate information

p33L43 FN 20Nov06 Advises that the midwife should not say the number of centimetres dilated someone is as it puts focus on numbers rather than how the woman is feeling or coping.

p37L22 FN 20Nov06 Greets and then goes to examine the woman in her bedroom. The cervix is 5cm dilated on vaginal examination. The midwife does not tell the mother the dilation (tends to avoid, see earlier field note)

Uncertainty and authority

p6L32 FN 21Oct07.
p3L21 FN 24Apr07
p4L10 FN 14Jun06
p5L16 FN 28Jun06
p4L10 FN 14Jun06

Chapter Seven On Professionalism

Orthodoxy

P3L26 Int 21Apr08 One midwife aligns the rise of active management and obstetric control over birth in the eighties and nineties as concurrent with the witch hunting of independent midwives. It was at this time that active management really swung in to place.

Professionalism in independent midwifery rhetoric

p1L18 FN 21Sept08 She feels, and her lawyer argued, that the ABA were judging her case on precedent or presumption of context, criteria and standards not appropriate to Ireland but to the UK where there are two midwives at each delivery. Where there is a supervisor of midwives available 24/7 to the midwife. Furthermore, in Ireland, the independent midwife is not allowed to stay with the woman on transfer to hospital thus increasing the woman's anxiety and disinclination to transfer.

p3L41 Diary 29Jun09 I get a phone call from a midwife asking about the make up of the ABA fitness to practice people. She gives me names and asks me what they do. She seems not to have noticed that she can access this information for herself. It seems the basis of her asking is that they may not be midwives, or midwives in clinical practice, or midwives with domiciliary experience. She seems to be using this as part of her defence. It does seem reasonable to argue that they are not people likely to be familiar with her context of practice and therefore are suitable to judge her practice.

p5L7 FN 21Sept08 At the fitness to practice hearing the midwife described herself as an alternative health practitioner – which I gather caused some concern to ABA. She was not claiming to be trained in all alternative therapies but in some. Though she does use herbal and homeopathic remedies, she was able to argue that these were initiated by the woman herself that she could not be held liable for their effects, side effects etc.

[I can very much see how the whole ABA FTP process is about ABA being seen to do something about a poor outcome that might (but might not) be due to the actions of the practitioner. It seems that all they can work on is what can be pinned down (or not) to documentation. There seems only to be consideration of decontextualised policies and procedures, applied from contextually different (and therefore inappropriate) settings.]

p7L19 FN 21Sept08 'I'm out in the stix with no support from anyone – particularly not the ABA'

p1L25 FN 21Sept08 The FTP process was 'soul destroying' 'I was killed asking the relevance of the questions put to me' [much seemed to her to be irrelevant to the case, the particular woman or her professional decision making skills]

p3L27 FN 04Dec08 The midwife argued very strongly that ABA do not seem to have to be accountable to the public. They should be open and transparent about how a decision like section 44 [which prevents practice in the interim between investigation and FTP adjudication] is made and by whom. They should be transparent about what grounds on which they decide there is prima facie case. None of this is open and thus she argues that they cannot (but should) be held accountable for these processes.

p3L42 FN 04Dec08 She doesn't feel that justice is available to the single petitioner in the face of the power of ABA, medical powers and legal / statutory sanctions.

Cautious, conscientious, conservative and careful

p6L43 FN 21Sept08 'I was so controlling, cautious and conscientious' [very much supported by the next comment] 'It never entered my head that a baby would die on my beat.' ['on my beat' very much a metaphor from policing and control]

p7L37 FN 21Sept08 'I always stay three hours after delivery, I take a lot of precautions' 'I knew I was in a risky profession'

p5L8 Diary 10Nov06 Talked about feeling very exposed and she said 'you are very exposed' and feels that after twenty years it's not worth it [I take her to mean taking on difficult cases and fighting the system] and 'I'm not trying to scare you'. Considers herself to be 'conservative and careful'

p3L14 FN 17Oct06 there were different schools of thought, those like her whom she would consider more conservative 'the voices of reason'

p23L16 Int 17Aug06 'Personally speaking I would have very very strict boundaries for myself because I would have been taught that from England but I just know that there are other midwives out there who do not have those boundaries and I think that you have to work within a scope you know I think that you have to work within a scope to be safe and if you're going to tinker around, pushing boundaries more, you now than you are able as a midwife then you're asking for trouble and don't blame the consultants at all.

p6L1 FN 18Sept08 'I err on the side of caution' [I tell her too that in my interviews / experience every midwife describes herself as erring on the cautious and conservative.]

p1L22 Int 20Jan08 'The course [Bachelor in Midwifery Studies BMS] was very good for that. It sort of brought everything together. I mightn't have the evidence at my fingertips but I know how to access it, where to get it if I need it.'

Updating

p8L49 FN 20Nov06 Talks with her midwifery colleague about NRP (Neonatal Resuscitation Programme) refresher coming up on Thursday, they are discussing tips for learning things off.

p17L22 FN 20Nov 06 'NRP study day 'sure we can always do that another time' [This demonstrates the close relationship between them and the school.] – 'they have been very supportive'.

p4L31 Diary 15Mar07 (Autobiography) Biggest challenge to me was that I (anyone new starting) should be up to date with all their courses, cannulation, suturing resuscitation adult and neonatal – important to have these documented - for my own protection – 'have to protect yourself' – against allegations of ill preparation / incompetence – should go through that meticulously and defend myself.

p4L20 FN 11Jul08 tells of [named hospital] where the AN ward staff get all panicky when there's a birth on the antenatal ward. It's such as shame to hear that attitude even from midwives. There was talk of workshops in the ward to promote normal birth which this midwife was very favourable about but then she heard that they were talking about doing workshops on abdominal palpation and she said 'that's not what workshops on normal midwifery about, that'd be a disgrace to midwifery, it would be condescending, that they should be able to update their practice just by rotation of spending a few hours on a antenatal ward of clinic'. The lead midwife there on labour ward and the practice development co-ordinator were doing it and but she was much more inclined to

promoting normality by promoting midwives confidence to practice autonomously to make decisions and to face the climate of fear that is prevalent in hospitals about birth and risk and abnormality. She put it down to buck passing, not taking responsibility for their own midwifery decisions or supporting each other in this. 'Its not skills they require its confidence and a change in attitude.'

'Sometimes I think I come across as too aggressive'

'An antenatal birth should not be seen as terrible – its totally internal politics between wards and areas. You can promote normality by encouraging ways of being 'with women' and by believing that birth is normal.'

This midwife says she is going to the normal birth conference in Bavaria and is hoping that she will get some ideas for innovative practices that she can bring to her own practice and to such promoting normality courses as mentioned before.

p14L49 FN20Nov 06 talks about always learning in community midwifery practice – not always referring to clinical skills but about interactions with others – be it how to approach hospitals or situations. Talks about the need to be open to other ways of doing things and in this regard having contact and support of other midwives is a good and healthy thing.

P15L19 FN20Nov06 Talks of another midwifery colleague as having done the newborn examination course in the UK (has practiced in community there too Edgeware birth centre) or perhaps just that they all (scheme midwives) might consider taking on newborn baby exam as part of their role. She is at present ambivalent about that, thinking it a bit beyond her scope – definitely at present - but maybe it might be a good thing.

Scope

p5L23 FN 21Oct07 I spoke of my fear that this study might make independent midwives more vulnerable. She said that she would be scared that this study could reveal all the weaknesses and quandaries of independent midwifery. To the point of ridicule. That there would then be no hope for autonomy and advocacy for independent midwifery or for women. ' I couldn't bear that' If it showed that independent midwifery was too difficult, that there was no insurance, that midwives made stupid decisions or that they went beyond their scope of practise.

p2L46 FN 21Sept08 Turns out that this birth was a breech presentation that didn't become apparent until second stage. This midwife had seen and attended breech births during time in overseas. She mentioned also that breech not taken as indication for caesarean section in her time as trainee midwife.

She also said that she had had breeches in intervening years and never found them to be particularly problematic, in fact says she smiled when she saw it was a breech, she obviously felt comfortable delivering breeches. She cites Mary Cronk and another midwife (UK? US?) as being very positive and supportive of breech delivery at home.

Accountable

p6L32 FN 11Jul08 I asked about breech birth at home. The midwife says she can deal with it if undiagnosed. She tells a story of one such: The baby needed resuscitation but not transfer. Got the GP to check and at the six month check the baby was perfect [This is an example of an underlying anxiety that, with babies needing resuscitation, there may be some sort of underlying neurological damage that doesn't present until later. I didn't get a

chance to talk more about that, or how it might be an exemplar of how the independent midwife is left to 'worry' or have a concern about a birth or aspect of care many weeks and months later the actual end of care. This is an aspect of practice that I have come to be aware of but haven't heard too many others allude to. I might look for this elsewhere; it is quite a significant emotional / psychological drain potentially to balance all the very positive aspects of home birth.]

This midwife trained in Dublin in the 1970s and at that time students still got home birth and domiciliary experience. She also got experience delivering breech whilst working overseas.

p3L23 FN 18Sept08 'there is an element of defensive practice [that has become engrained in independent midwifery and the home birth scheme] like dropping VBAC or anything outside of the scheme guidelines.' '[risk, or consequences of reaction?] too great to chance it'

p5L19 FN 29Sept08 spoke about both she and another midwife having unexplained neonatal deaths at home birth and being examined locally by the steering group with an obstetrician and a paediatrician. No cause was determined and no professional practice shortcoming was noted. She had talked about facing the fear and going to speak with the paediatrician directly herself. She feels that it is the not knowing each other and not addressing the issues face to face, that makes communication bad and arouses or allows suspicion of what's going on.

p7L5 FN 15Sept08 Talks about frustration of meeting with the scheme, talking about charts, meetings and routines but not used for professional peer review or talking professional practice issues.

p8L18 FN 15Sept08 It's a problem that we [independent midwives] don't talk [to each other]' in California we scrutinized each others notes etc and spotted where things needed to be done or where things had been overlooked or not followed up – much more than the doctors ever did. 'the midwives were way better, we couldn't afford not to be doing a good job.'

p6L22 FN 11Jul08 'the perception may be that being professional is being aloof and hard but it isn't.'

p7L1 FN 11Jul08 In emergency I get so calm it's unreal – robotic nearly. I trust myself to do whatever is right. I have great faith in myself – I'm not boasting but it's just there. Midwifery is a most humbling of professions. You can't afford to be arrogant – you'll be brought right down – it's a kind of a philosophy.

p4L34 Diary 28Aug06 'Autonomous practice, in my view, requires levels of skill and expertise that are not nurtured or developed among midwives in our medicalised system of maternity care.'

p5L45 FN 21Sept08 This midwife is familiar and comfortable with the use of various herbs, homeopathy and Bach remedies [She is not, I gather, formally trained in these therapies but the women she has attended use them so frequently that she has become familiar with their routine use – dose, indications – side effects ? contraindications? I have two thoughts here, the experiential element of learning in apprenticeship and familiarity. These are not aspects of teaching / learning that are valued or allowed in main stream professional education and yet they are a very real way of learning.]

p7L10 FN 18Sept08

Information and consent

p1L28 FN 27Jul07 Told the story of a case in Donegal where a mother refused the Guthrie (metabolic screening) test. The child was then made a ward of court (under the Child Protection Act 2001), the test was done and then the child was given back to mother.

p1L32 FN 27Jul07 Showed me guidelines for vitamin K with incident report form if refused. [That the mother has to sign refusal rather than consent strikes me (and the midwife) as bizarre.]

p7L26 FN 15Sept08 gives example of effect of scaremongering and guidelines in that the vitamin K now has to be signed off if NOT taking ,’ they [parents] get to thinking that it’s [vitamin K administration] a must, which it isn’t

p6L5 FN 15Sept08 Recalls in her own training and practice that she was as guilty as everyone else of giving drugs etc without real informed consent

p4L13 FN 24Apr07 The midwife makes initial contact with the hospital to suggest that the woman may be transferring in, and to prepare for her.

P5L32 FN 24Apr07 Later the same midwife contacts the hospital to say that the baby has been safely delivered at home.

Evidence based practice

p3L42 FN 21Oct07 This midwife had worked in the community as a student she met an independent midwife who exposed her to ideas she had never heard of before such as physiological third stage ‘this was before the Bristol trial’ [demonstrating this midwife’s familiarity and ease with clinical trial evidence]

p16L33 FN 21Oct07 Going through the hospital booking notes the midwife says ‘we prefer to go by the scan dates’ [this strikes me as odd as the independent midwives usually go by mothers own history, and evidence would suggest that when scan results are within 10 days of the mother’s own dates that the dates aren’t moved. I wonder if this is a result of the relationship with the hospital / obstetricians and their standard practice ? I forget to investigate this further with the midwife] The mother reports that her mother went three weeks over on all of her children.

p7L13 FN 29Sept08 The midwife tells the mother that the hospital prefers to admit women at Term plus 9 or 10 for wellbeing scan, but that best evidence suggests not strictly post term until 42 complete weeks.

p1L31 FN 16Oct08 SM 99% Ok with NICE but some things – like only allowing a 2 hr second stage – not so happy with so reluctant to accept ‘bound by’ – concerned that ‘many NICE recommendations not based on evidence, but on expert opinion, and it’s not our opinion’

P3L43 FN 19Feb08 Of evidence / studies ‘you can lead the studies any way’ ‘evidence based is OK but I don’t (necessarily) believe it – go with gut.

p4L9 FN 19Feb08

p6L15 FN 21Sept08

Documentation

p5L37 FN 21Oct 07 ‘I’m a real scaredy cat’ ‘We cover ourselves all the time, check everything twice’ do beyond the normal – put thinking caps on until resolve to a happy

feeling' When I ask about 'cover ourselves' She says 'write notes really well or contact their GP, share responsibility write a letter.' 'Honesty, we don't bluff.'

p4L40 FN 21Sept08 She went to other room and dug out some of her charts for me to see, to go through. She asked me to pick a couple at random and I tried to pick an older and newer one. She wanted to find some exemplars of her work and of her documentation which feels is really rather good and not as portrayed in her FTP hearing.

From Elizabeth Davis's 'Heart and Hands' book appendices she uses a questionnaire to the mother about her history and expectations for home birth. She asks them to fill it in and they and she discuss what they have written. In relation to her FTP case this practice was a godsend because she was able to argue that the woman was well informed even though as a historian the woman was poor, and was judged to be unreliable about the antenatal period. She would for example deny being told stuff but then when it was put to her would also say 'oh yes I do remember hearing that'.

Private payment and added value

p31L31 Int 17Aug06

Q: Do you feel that changes the relationship between you the midwife and the woman who's coming to use your services ?

A: I think because they're paying me and they're paying me up front, I think those women initially expect huge things from me because they're paying me cash they're paying cheques there is money changing hands and I feel because of that as well that I have to give it my absolute best

Q: and how do you do that ? what's ..what's..?

A: I just give extras Colm I suppose like I give them. One of the midwives in Cork in particular has a midwives clinic so that the women come to her, for instance I feel that if I'm being paid for this private service that I need to go to their home so that's that's an awful lot of extra travel for me but I feel that that's the best I can give it, to give them a gold standard of service so I always visit the clients in their home, I always give them an hour and I would always do a thirty six week visit at night, none of the other midwives in the country I don't think do a thirty six week visit at night when both parents are there, because the dads are often missing for rest of the antenatal care, working, so I do like a two hour stint at thirty six weeks at night when the kids are in bed and you know that I think is quality as well. And I would have a library of books to give out to them and what I call my birth story book that I give out at the end of labour. I would, they wouldn't have to hire TENS as I have a few TENS machines, I have my own birth balls to give out. I usually give out aromatherapy oils and stuff like that I would have a homeopathic kit as well whereby they would know the remedies themselves, I wouldn't give the remedies myself 'cos as a midwife I'm not a homeopath and I haven't done any training in homeopathy but I would have the kit and they would choose from the kit if they knew anything about homeopathy as to what they wanted. So they're the kind of extras that I try to give for the fee (for the value for money) yeah, because really feel I have to give value for money if they're shelling out. It's trying to make it that bit different you know by virtue of the fact that they're giving me money I need to give them quality and they're the things I can give to provide a quality service, Postnatal as well, all the visits would be at home. In Cork I think they're restricted din the scheme to I believe something like four visits, I would do ten visits and again they would be like every day for the first five days

and then the flexi days after that would be flexed according to the client not according to me. So that's, they're the kind of things that it a little bit different whereas in the system they wouldn't be given that hour first off, time is hugely important to women and you know no matter how small the complaint is the very fact that they've voiced it to you and you've said its normal or it's not normal and we'll try and fix it, it means a huge amount to them. So time is, a lot of the women say to me , you know with hindsight, they paid for my time and that's an awful thing for a woman to have to say – that they had to pay for time but that's what they ay they paid for – they paid for me to listen and they pad for me to explain. I feel that I respect women an awful lot more for that, I put in the time. I give them the information for them to make their own informed decisions and I respect them for that because they know an awful lot by the time you know labour comes and if they do have to transfer in labour , I can see it myself, they know exactly what they're not having and what they are having and it's because I've genned them up on different aspects of labour really, and you know the pros and cons of rupture of membranes and of syntocinon acceleration and they know all of that I gen them up on that and I do a birth plan with them in case they do have to transfer into hospital. They're very confident going into labour, be that at home and it end up in hospital or be that at home and they stay at home and they know that because I've taught them as much as I can, they know that I know that they can make their decisions freely when labour comes.

Counter examples

p4L21 Diary 18Sept07 One midwife has concerns about practices such as syntocinon injection for third stage. (It is not licensed for IM administration but for IV.) She has concerns if things go wrong they may not be covered (insured or defensible). Also that some practices such as recommending fennel tea as a remedy is not evidenced for poor feeding, and furthermore that giving it by bottle is contrary to evidence baby friendly breast feeding guidance. She particularly asked me why I hadn't spoken to those midwives about that.

Subversion

p2L40 Diary 31Mar09 A midwife mentioned that she has woman over 40 years old who is seeking a home birth. In her letter of referral to the hospital the midwife said she is intending home birth. The hospital noted the home birth plan and did not protest the age criterion. The midwife is assuming this is tacit approval and is not pushing for clarification.

p38L49 FN 20Nov06 A midwife tells the following story: A woman with a low lying placenta, who lived one hour away from hospital, went for an antenatal check again at 36 weeks. Despite the midwife having prepped the mother to ask the doctor clearly whether it was still low lying, he wouldn't say clearly to her that it was Ok for home birth. The midwife felt that he was testing her, whether she would still offer or 'allow' the woman a home birth, despite the woman saying to him that the midwife was saying to her 'no home birth'. He suggested to the woman to stay in hospital rather than travel but he not say clearly whether home birth possible or not. The midwife suggested that the woman say she would stay with her sister in Cork (thus satisfying his request to be close to

hospital) and yet she went home. The midwife did feel however that the woman was therefore vulnerable and so agreed to come and check if the woman felt she was in labour (She had had a 40 hour labour last time).

p22L50 FN 20Nov06 I notice that she writes 3cm dilated not the 4 cm she told me.

p37L25 FN 20Nov06 I note a tendency to record details that are more favourable for the woman, in terms of duration and progress, ie. recording observations a little later and progress a little less than actual, to allow leeway, for more progress at next examination, for more time to the next examination.

Chapter Eight Dilemmas

Freebirthing

p8L18 FN 21Sept08

p5 L8 Int 21Feb08

L50 FN 21Feb08 Citing parents that were challenged about unattended (deliberately) birth in the past. This and other issues were what spurred Cork /Southern region HSE to set up scheme in first place.

p2L35 FN 16Oct08

p1L28 FN 27Jul07

p2L41 Diary 02Apr09

p31L35 FN 20Nov06

p1L34 Diary 12Dec07

p6L14 FN 10May06

p6L19 FN 10May06

P13L26 Diary July 2007 At a meeting between independent midwives, and the HSE, a non-midwife said that they felt that a court order was an appropriate response when a woman will not comply with professional advice. This is disputed by the midwives' argument that 'you can't coerce people'.

p2L1 Diary 12Dec07 When I said that ABA's suggestion that they might advise that it be illegal to practice without insurance that it was inclined to make me feel like doing it anyway, to spite them for backing us into a corner, another midwife said she felt so too. Saying, 'OK I'm going to, go on arrest me' to see what they would do. She said that she was glad to hear that that had been my reaction too.

Duty of Care

p6L15 Int 13Feb07

p7L23 FN 21Sept08

p32 L67 Int 05Jun07

p12L16 Diary 11Oct07

p6L15 Int 13Feb07 'you've given your word, there's an obligation' to the mother, to be there

p2L1 FN 11Jul08 One midwife described a doctor saying to her 'these women wouldn't be able to have home births if you didn't offer it.'

p10L1 Diary 24Jul07 / Autobiography No one in HSE medical side seems to see that some women will choose home birth despite high risks and that independent midwives will feel they should be able to attend them . Certainly the feeling is that insurance companies wont want to cover home birth and so the people setting the birth agenda are other than the women themselves or midwives.

Guidelines

p1L31 FN 16Oct08

p6L31 FN 20Nov06

p7L5 FN 15Sept08

p4L50 FN 18Sept08

p7L25 Int 13Feb07

p1L28 FN 27Jul07

p7L22 FN 15Sept08

p11L45 Diary 11Oct07

p16L33 FN 21Oct07

p27L8 FN20Nov06 The midwife gave the mother the Cork scheme form to fill in, and talked about ineligibility criteria and emergencies that require transfer. She said that there have been babies that have died on the home birth scheme, that the cause has been unknown and that that can also happen in hospital.

p1L18 FN 16Oct08

p7L37 Diary 25Apr07

p6L24 FN 11Jul08

p3L23 FN 18Sept08

p3L32 FN 20Nov06

p7L35 FN 15Sept08

p2L33 FN 11 Jun08

p7L27 FN 18Sept08

p10L12 Diary 24Jul07

p3L23 Diary 05Jul07

p2L36 Diary 12Sept07 Some midwives working in a hospital based home birth scheme seemed concerned with keeping the scheme, of not bringing it into disrepute. One said 'all we would need is an undiagnosed breech at home for the scheme to be closed down'.

p4L42 Diary 18Sept07 One of the midwives is ribbing me not to bring independent midwifery into disrepute

p3L4 Diary 12Sept07 Stay strictly within the criteria 'to protect the service' and undiagnosed breech at home and we'd be closed down'

p8L35 FN 21Oct07 Feels that there is a circumscription on her practice by being in the scheme in that there is a feeling amongst her colleagues that they need to protect the scheme and therefore they should not practice outside its strictures. 'say I was doing a VBAC, which is not permitted with Cork guidelines, they would feel bad of me, that I could be jeopardising the scheme.

p4L1 Diary 14Nov07

p5L28 FN 15Sept08 As I ask about professionalism / relationship with cork scheme she says 'there are too many rules and regulations' such as cut off point for haemoglobin levels at 10.7

Negotiation of guidelines mentioned in footnote. See also communication and liaison above and relationships with others

P7L42 FN 20Nov06 It seems that previous caesarean section is the only absolute exclusion from the scheme there are several others but they are 'asterisked' which seems to mean that they are negotiable with the hospital consultant.

p7L20 FN 29Sept08 There was a discussion among the midwives about finding a sympathetic obstetrician for the individual medical maternal assessment cases

p1L34 FN 20Nov06 One midwife talked about spending years trying to negotiate with the HSE to get a workable contract between them and the independent community midwives to provide home birth services, 7 years before it happened.

P14L26 FN 20Nov06 Reminds me of a midwife's story from yesterday of a very overweight woman who otherwise was well and was asking for a home birth. The

midwife could find no other reason for declining to take her on but when she went in for scan they took her blood pressure and it was elevated. The doctor rang (the has been only time the midwife has spoken with him or any of the hospital obstetricians) and started to 'rant' at her about the risks and dangers and unsuitability etc. The midwife says she 'let him at it' but then said 'well of course if she has elevated blood pressure she's not within our remit and of course she wouldn't be taking her on' and 'by the way what was the position?'. It was cephalic and she says he said that he was thinking of sending her home with the idea that maybe the hospital visit had put her blood pressure up and that the midwife could continue to monitor her. All in all she thought he seemed much chastened and more receptive her and he felt that she was at least not unreasonable.

Transfers

p1L34 FN 19Feb08
p7L5 Int 17Aug06
p7L4 Int 13Feb07
p17L16 Int 11Jul08
p10L41 FN 21Oct07
p27L47 FN 20Nov06
p29L19 FN 20Nov06
p4L12 Diary 02Oct07
p4L4 Int 09Dec08
p7L19 FN 30Nov06
p8L12 FN 20Nov06
p14L43 Int 17Aug06
p8L24 Int 13Feb07
p5L33 FN 11Jul08
p45 L15 Diary 18Apr06
p34L6 FN 20Nov06
p4L4 Diary 13Oct06

Status of the fetus in Ireland

p22L2 FN 11Jul08 'It's their baby it's their decision.'

p6L32 FN 21Oct07 The midwife describes a fundamental belief in autonomy, giving women the information and the decision clearly to the woman. 'They're making health decisions here about their pregnancy, their baby, their body. Midwives can make recommendation within limits, can specify limits [of normality ?]

p30L4 FN 20Nov06 The midwife said 'hello baby' during the abdominal palpation

p17L23 FN 21Oct07 The midwife stands with her hand on the woman's abdomen / uterus for 2-3 minutes and says 'Its nice to tune in with the baby, [for it] to get used to my voice'

p11L29 Diary 11Oct07 A midwife tells about case four years ago about a breech diagnosed by her and sent to hospital to confirm presentation. The woman came home and refused to go back to hospital. The Attorney General was asked to judge whether the rights of child overruled the mother's decision. He said it was not applicable at this term; the rights of the unborn child were usually considered for earlier in a pregnancy regarding abortion and so woman had her home birth (by breech) with the midwife.

Politics and Reputation

p5L23 FN 21Oct07

p7L19 FN 30Nov06

p5L25 Diary 11Nov06 ‘The midwifery profession in Ireland is moribund.’ We can’t get midwives to be politically active about anything. There a very few individuals in various midwifery organisations who are willing to be active tackle issues, be heard, put the work in for change.’

Political action sentiment

p8L37 FN 29Sept08 One midwife recommended that midwives keep referring these cases [where women are outside the home birth criteria] back to the hospitals and get the hospital to deal with facilitating the woman. ‘Don’t give them a loop hole; push the hospital services to do it.’

p2L7 FN 16Oct08 ‘We’re now pawns in a political hoo-hah’

p5L22 Diary 28Aug06 A midwife talked about teaching and being politically midwifery aware. She talked about getting in at students from the very start and pricking their consciences. She suggested it was like being a grain of sand that will turn into a pearl by the time they qualify and that they will therefore be willing to fight the good fight for women and midwifery.

p9L33 Diary 24Jul07 During coffee someone had heard that one night [a named maternity unit] had 42 deliveries. One midwife was shocked and said they should (as they do in England,) shut the doors for safety and respect to the mothers. Another midwife they explained why they won’t because if close doors to public women then they must also to private women which would be unacceptable (to those women and Obstetricians). She explains further to the first midwife that Dublin Hospitals have a different financial arrangement than rest of country. They are ‘voluntary’ hospitals and have a much tighter link between their income and the number of private ‘patients’. The first midwife was horrified. All of us are appalled really, it is not acceptable, but that’s how it is and has been.

p2L3 Diary 17May07 One midwife gave me a copy of the HSE advertisement from two days looking for expressions of interest in an expert advisory group (EAG) She reckons independent midwives all should apply.

p7L13 Diary 20Jul07 Several of the independent midwives have been in contact with each other by e-mail and have decided to put forward a united front to the state claims agency (SCA) calling themselves (ourselves) IMI Independent Midwives of Ireland. Used the word ‘pretend to be’ [united]. They plan to use Cork schemes ‘as our basis’ Our collective line is to be: ‘we’re doing the service you’re not providing’ and ‘of course we’ve got governance’ but basically say very little ‘to find out’ what they SCA are thinking / come up with. One talked about us / independent midwives having ‘peer review’ [certainly Cork does and others have had some sort of peer review] write to

p17L7 Diary 26Oct07 One midwife is encouraging women who are due after March to write to the chair of the DBIG about the prospect of birthing without a midwife, that that will scare them into doing something.

Political decision not to challenge

p7L17 FN 15Sept08 'I'm too old to be fighting city hall'

p3L33 FN 11Jul08 talks of an ambivalence about fighting the hospital system in Ireland, about choosing her battles carefully and not wasting her time or her energy.

p9L48 FN 21Oct07 '[Named independent midwife] and I used to say we'd just do our little bit. Keep our heads down and deliver babies, and hope that'll make a difference.'

p8L37 FN 29Sept08 One midwife reminds us that water birth has not been mentioned in any home birth criteria / guidelines and so it is under a midwife's own judgement. (She sees this as a positive flexibility, and that if DBIG had considered water birth separately it might well have been contentious and not allowed.)

p8L25 FN 11Jul08 Not that I haven't the courage, I just don't want to have to take on the whole system.

Chapter Nine Insurance

The following is the more complete extracts of the conversation / interview on insurance that forms the basis for much of chapter nine.

p3L19 Int 11Jul08

Q Why do you think?... I got the impression yesterday that you thought this HSE arrangement [memorandum of understanding] would help [home birth and independent midwifery]?

A I do think, well first of all the HSE from a lot of midwives who are not practicing in this way now it's seen more of a stability in the insurance and more of a support. If they would come along with us and give us you know indemnity insurance, to be seen as some kind of support for this model of care.

Q I agree.

A And I think they would be more likely but also things have gone to the stage now its, midwives are talking more of practicing in an autonomous way. Its more, its more I suppose thought of as the way to do the midwife led care. Maybe independent practice or some [other model], not so much working completely within the medical model. They are asserting themselves again but it's taken a long time but they are getting to that stage. They see it happening in a lot of other countries in Europe and around the world. So they are looking at the way they're practicing themselves and letting go of a lot of their skills. So I think there is a lot of awareness there that they could legally be practicing in their own right.

Q So its not having the insurance, not having HSE blessing for it has made it dubious as to whether they can go about it [independent home birth midwifery].

A Well it has made it more just a very small alternative way of practicing, not so much a sustainable way of practicing. And the grant was even less than it is now, the women would either have to [pay extra], I think there was a lot of lack of knowledge really about the fact that the insurance companies will cover home birth and have done so for many years. There was a lack of recognition of home births even among the midwifery profession because it wasn't supported even by midwives. And still isn't in a lot of cases.

Later extract p12L11 FN 11Jul08

Q Tell us about this, they talked last September about withdrawing the insurance, they talked about removing it in April and they are still saying about it disappearing in September. What would the removal of the insurance do?

A Well I would be very, first of all it's created a lot of instability and I've got a waiting list of women who are like me waiting to see if I can get insurance and I'm waiting obviously. So it's created a lot of instability in planning forward, even in doing things like if I wanted to set up a small birthing centre I don't want to do it until I know I'm going to have reasonable insurance. It would mean, it means also for the women that this service is almost not legitimate, where they are having all these problems. It is still very much a service that is covert and it seems like that to us as well. Obviously it affects all of our practice too because we are fighting and having to go to all these meetings and struggling for more than a year now and even before that the INO were

threatening to pull it. At least that's the feeling that this is somehow or other not such a legitimate service that we are offering because of all this, we are more at risk than we know ourselves, we are not.

Q What about if they didn't give it in September.

A Oh yes, you asked me that question. Well I would at this stage I've a lot of experience of birth, a lot of good experiences but I would be very reluctant to practice without insurance in Ireland.

Q Why, what does it mean?

A It means that I could be sued for more than I, it could mean that everything I've worked for could be in jeopardy if I was personally sued.

Q Like what?

A My home and my, well basically my home would be the main thing, it wouldn't be so much my reputation because I feel very strong that I wouldn't ever do anything, do substandard care or put any mother or babies lives at risk or do things that were jeopardising their care, I don't think I would do it.

Q So your practice wouldn't change?

A My practice wouldn't change no, no.

Q So its not that the insurance makes you practice better?

A No it does not, it would have nothing, I would practice in the way that I'm practicing now. I wouldn't do anything that wasn't correct procedure in my view but I am quite laid back about birth but I do all the required care. But I wouldn't at the same time be doing things just for the sake of doing them. But I would keep, even with the way I was taught you know in training school I wouldn't be diversifying too much but the one thing I would, not to much but the one thing I would be very different about is I wouldn't be doing examinations, vaginal examinations like they do in hospital, I would do what I felt was necessary. I would do the assessment basically similar but the first and second stage I wouldn't be with the talk so much but I would have a very big reference to that, especially in second and third stage. So it wouldn't be that different, but I wouldn't change my practice, having the insurance or not having it wouldn't change my practice on bit I don't think. I wouldn't see it at all related to my practice, I would see it as related to some event that I couldn't have done anything different but I know how people's perceptions might be different. You could end up in a court with either the woman or the partner or husband would take you there but it would be your own professional body or a doctor or someone who perceived the fact that you are not doing the standard.

Q But that could happen anyway?

A That could happen anyway but at least you'd be protected with insurance, its something about being a professional as well to me. That we have, that a professional, we are seen as having cover, to have insurance cover.

Q Yeah who is saying that? Where does that come from?

A Its coming from today's world I think, modern world that it seems to be part and parcel of our way of living now. And its more I think a history in Ireland of all this litigation as well, maybe not just Ireland but its more than it is now, it was in the past more likely that people would take that line, would take it into court to get compensation. It was that kind of culture. It seems to be part of being a professional to have insurance cover. Its part of people's way of working now and it seems, I don't know who's saying it but its the way that we are set up as a professional group, medical, midwifery, lawyers

and accountants all those people that we would have as a comparative would have insurance cover and we see ourselves as being that type of professional as well. Where there are, where something might go wrong which you couldn't prevent but at the same time it doesn't mean that people wouldn't take you to court. I don't see it as always that I practice in a substandard way if someone takes me to court. But having the insurance would not change my practice.

Q Okay yeah

A But then I have to maybe analyse why I wouldn't work without insurance I'm so confident in my practice.

Q That was my next question; would you or would you not?

A Well a lot of the women have said to me I'll sign a letter you know to say I won't take any action against you and I've said to them well it might not be you but it might be a doctor who thought I didn't do what was necessary. Or An Bord Altranais might.

Later extract p18L19 FN 11Jul08

Q Some people in England have decided to continue practicing without insurance.

A I know they have yes, I can understand it.

Q Can you explain why?

A Because there is a lot of trust, there's a huge trust between the couple or the woman and the midwife, there would be, the women would be very confident in the practitioner that they wouldn't do anything but that's just surrounding their practice. But down the track the cases we've heard from the hospital situation about cerebral palsy and various things like that. The way I would look at it is I might not have done anything but there could be questions asked down the track if the baby did turn out to have something that could be attributed to labour care. That would be more my concern that something might come back that you had done everything you felt was professional but something might come back that is queried by a group of professionals say examining baby later on who has a problem. Or a mother, say for example if a mother got a perineal tear and the suturing was perceived as not being adequate.

Q You can identify.

A There would be things like that, but normally if the woman had a tear I would bring her to the obstetrician to do that, suturing her tear. So that wouldn't be a big thing in my mind at all, it would hardly enter into my mind but the baby often would enter my mind that I've seen and heard cases that happened x number of years ago and the baby then was diagnosed as having cerebral palsy, usually that would be the one. And it comes back to the court, but there has been identifiable lacks in care from the notes.

Q So the courts don't adjudicate it on whether your practice was defective or not.

A They don't often and that would concern me. I often see those cases coming up and think you know that the care seems to be quite okay but they would still rule against the practitioner or the hospital or whatever. That worries me that type of thing that its judged by non-professionals, well they do have expert witnesses and usually there is substandard care somewhere along the way. But its still, you have to go through all that and not having insurance is a bit scary.

Q All the more so.

A Yeah I would, I don't think I would practice at this stage, I might have a few years ago. But no, I wouldn't be prepared to lose my home over it. I definitely wouldn't. I wouldn't, I would be very passionate about midwifery and doing what I'm doing but I wouldn't be prepared to, certainly I wouldn't be prepared to lose my reputation, my home.

Q And it is something, you've identified something that there is about reputation of the profession if it can't be insured is it reputable?

A Yes, yeah is it? A lot of the women have said to me [when] I said I wouldn't practice without insurance and they said no I wouldn't expect you to. I said I see it as part of being professional nowadays, it was different years ago. But I do see it as part of being professional.

Q So somehow money and insurance has got tied into what professional is.

A It has yes, definitely it has.

Q Money and insurance and payments confuses and muddies the waters, I think there's something in that that I need to look into.

A Yes, yeah well I think its like in the old days there would be bartering in giving the midwife things that would sustain her life, you know, food and all that kind of thing. But it's just an exchange, it's a commodity, money is a commodity and its part of our lives and you know there is a culture of litigation to a certain extent in Ireland. Its not so bad now but its still there, I think it's almost part of being a professional like we have our, we have our equipment to deal with emergencies and we have our equipment to deal with the normal. It's all, to me it's all part of that nowadays. It's just something like we'd insure our house, we don't expect it to go up in a blaze but at the same time we'd insure it in case it does. And I do look at it in a very practical way like that. That I would have that insurance there, I would have life insurance when the children were small, well I still have.

Q To have something.

A Just to have something, it's just a practical thing but maybe we are sold a lot in that as well but I wouldn't ever see the home birth women as being litigious but at the same time something could happen. And maybe, I've a great trust in the women not to do that but at the same time its really having seen what has come up that would be, they would get an award against the hospital or professional. It has made me very aware that it's something that is probably a good thing to have.

Q It's also I think something to do with the fact that no matter how much you've a good relationship with the midwife if your child has cerebral palsy you've no other way of providing for it. The only way to get the money to look after this child is to go through insurance.

A Yes, that has happened. That has happened, you can understand it, if they are trying to get care that is actually very expensive you'd do everything you could, you know, you'd almost give your life for the child, I know that from being a mother. You would literally give your life when they are small to do everything possible for them.

Q Whereas this society doesn't look after its handicapped people well at all.

A No, there are things that have improved but that obviously costs money and that is the reality of life. It's often not the couple but it's people advising them and families advising them that this is the way they should go, you know, take it to court.

Later extract p38L14 FN 11Jul08

Q Its funny I think independent midwives are not afraid of birth.

A They are not afraid no, no.

Q But the fear that's there is about the insurance, claims, laws.

A Yes that is absolutely it.

Other midwives' comments on insurance

p2L38 FN 18Sept08 'life's bigger than midwifery' talking that if there is no insurance, she will stop doing midwifery

p5L29 FN 21Oct07 One midwife compares this pressure against or vulnerability of independent midwifery and home birth to materialism.

She fears that anyone reading [this thesis] might / could / would read it in black and white and see this [independent midwifery] as an avenue not to pursue. However she feels that if or when a student meets an independent midwife and sees midwifery practice in the community, they are inspired by it more so than if they just read about it. It's not the same reading it.

p3L20 Diary 07Jul07 / auto My concern that ABA might make a statement about not being able to practice with insurance which in a situation where we cannot get insurance, would effectively shut home birth down and make independent midwifery illegal, was a great shock to her. She hadn't thought about that but maybe that is too sensationalist and extreme. I have little evidence of that but can see the parallels with the UK and the RCM withdrawal and now the suggestion that midwives 'must' rather than 'should' have insurance. The midwife said 'but who's protecting the midwives?'

p3L16 Diary 06Jun07 About insurance withdrawal, one midwife asked me to me to record 'I feel that my hands have been cut off'

p6L23 Diary 12Jun07 She wants to emphasise that INO insurance withdrawal threatens her / their (independent midwives) livelihood

p1L34 Diary 08May07 One midwife is very cross about it. That it is, and feels, very unjust that insurance companies should be dominating the home birth agenda, and that our union should be so acquiescent in this move. It is a mirroring of what happened in RCM in the UK.

p5L29 Int 09Dec08 'Well you occasionally get, well a few women have had it where the GPs have said they are not going to support them with home birth. So they've gone and got another GP which happens quite a lot. Or they would say okay but as long as I'm not involved, they will worry about it because their insurance.'

p4L31 FN 16Oct08 'I've already done one without insurance'

p13L11 Int 01Feb2008 'It's scary, but I suppose its scary when you go out first, its not even the money because you know money is money but the fact that you are going to be dragged through court by somebody who has no other motivation than the money. And the insurance company making, its like [named midwife's] case where you know she wasn't able to clear her name because the one [the insurer] decided to pay the other [the claimant] and the lawyers got paid and the people left behind where the mother and the midwife, it's crap. So I don't have any faith in that the insurance will protect us when it comes to being dragged up in front of the courts.'

Chapter Ten **Discussion**

p6L17 Int 09 Dec08

Chapter Eleven **Conclusion**

p1L35 FN 21Feb08 (in footnote)

Appendix Two

Independent midwives' professional, research and academic achievements.

This appendix demonstrates that the midwives who practice independently in Ireland (most of whom participated in this ethnography by allowing me to observe and speak with them) are much more than research subjects. They are actively engaged not only in independent domiciliary midwifery practice but also in midwifery research and midwifery politics and birth activism. Please note that this record may be incomplete and not all names cited participated in this ethnography.

Professional Practice

The Home Birth Association of Ireland (HBA) produces a quarterly newsletter that regularly contains women's birth stories telling of their home birth experiences and of their relationship with their midwife. Women's birth stories have not made up part of this ethnography but the warmth and positive regard the women have for the midwives is very evident in their writing. The HBA website can be accessed at www.homebirth.ie and was last accessed on 10th September 2009.

Postgraduate research study and accreditation

Canning, Philomena (1997) A Participatory Needs Assessment for a Primary Health Care Project for Travellers in Ireland. Unpublished MSc Thesis. Flinders University of South Australia. Adelaide

Engel, Christina (2000) Towards a Sustainable Model of Midwifery Practice in a Continuity of Carer Setting Unpublished MA Thesis Wellington, New Zealand, Victoria University.

Mc Loughlin, Clíona (2001) Perceived views of midwives regarding their scope of practice and their educational needs Unpublished MSc Thesis Dublin, Trinity College Dublin

Millar, Sally (2001) Outcomes of out of hospital births in Ireland: a prospective, descriptive study Unpublished MSc Thesis. Dublin, Trinity College Dublin

O Boyle, Colm (1997) To Test the Predictive Validity of the Childbirth Self-Efficacy Inventory. Unpublished MSc Thesis Queen's University Belfast.

Sheeran, Bridget (2007) The Journey: The experiences of women traveling long distances from home to hospital in labour. A Qualitative Descriptive Study. Unpublished MSc Thesis Trinity College Dublin

Research Publications

- Begley, Cecily M., O Boyle, Colm, Carroll, Margaret and Devane, Declan (2007) Educating advanced midwife practitioners: a collaborative venture. *Journal of Nursing Management*, 15, 574–584.
- Canning, Philomena (2000) The Contagiousness of Courage. *EU Midwifery conference Aachen*
- Canning, Philomena (2002) Midwifery at Primary Health Care Level: A New Strategy for Women-Centred Maternity Care. Conference Paper ICM, Vienna,
- Canning, Philomena (2003) Midwifery-Based Maternity Care Systems - A New Strategy for Women-Centred Care in Childbirth Omagh-Monaghan Coalition Health Conference,
- Canning, Philomena (2008) A Social Model of Maternity Care Socialist Workers Party Conference on Public Health, Dublin, Liberty Hall
- Cummings, Bridget (1995) Difficulty in Labour *The Homeopath* No. 58 pp 435-436
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- Cummings, Bridget (1998) Empowering women: homeopathy in midwifery practice *Complementary Therapies in Nursing & Midwifery* 4,13-16
- Daly, Deirdre, Millar, Sally , Gallagher, Louise and Biesty, Linda (2006) Midwifery-led care in Ireland: an education. *The Practising Midwife*, 9, 9, 26 - 28.
- Devane, Declan, Begley, Cecily M, Clarke, Mike , Horey, Dell and O Boyle, Colm (2007) Evaluating Maternity Care: A Core Set of Outcome Measures *Birth*, 2, 164-172.
- Engel, Christina (2009) The Road to Normal Birth *The Practising Midwife* 12, 6, 30-31.
- McCarthy, Anne , Millar, Sally and Evans, David S. (2005) *Maternity Services In The Health Service Executive Western Area: A Survey of Midwives' and Consumers' Views*, The Nursing And Midwifery Planning & Development Unit Health Service Executive Western Area.
- Millar Sally A, Daly C Deirdre and Ni Mhurchu Padricin (2008) Home birth in Ireland: changing times *Practising Midwife* 11 (10) 40 – 43.

Ni Riain, Ailis and Canning, Philomena (1998) *Women's Healthcare services in General Practice: A national survey of Current Service Provision and Attitudes of Irish general practitioners*, Irish College of General practitioners.

O'Connell, Rhona and Cronin, Mary (2002) Home Birth in Ireland 1993-1997 A review of Community midwifery practice *The All Ireland Journal of Nursing and Midwifery* 2 41-46.

Sheeran, Bridget (2007) The journey to hospital. *AIMS Journal (Association for Improvements in the Maternity Services UK)*, 19, 4.

Sinclair, Marlene and Colm, O Boyle (1999) The Childbirth Self-Efficacy Inventory: a replication study, *Journal of Advanced Nursing*, . *Journal of Advanced Nursing* 30, 6, 1416 - 1423.

Professional Representation

Sally Millar Appointed Committee member of the Western Health Board Domiciliary Midwifery Services Committee since 1996 – 1999

Independent Midwives of Ireland (1998) Submission presented to the Commission on Nursing (February 1998). *Unpublished*.

Philomena Canning (with Marie O'Connor, Kitty Ross Maria Dowd and Colm MacGheehin) made presentation on behalf of Midwifery Birth Alliance to the Dail (Government of Ireland) Joint Committee on Health and Children (2003)

Sally Millar Appointed member of the National Midwifery Advisory Forum to DoH&C, January 2003 – 2005

Mary Cronin served on the Domiciliary Birth Group which evaluated the Domiciliary Pilot programmes (DBG 2004)

Sally Millar, Bridget Sheeran, Elke Hasner and Colm OBoyle served on the Domiciliary Birth Implementation Group subgroups (DBIG 2008)

Elke Hasner serves on the An Bord Altranais (ABA) Midwifery Committee 2009

Sally Millar and Colm OBoyle are Chair and secretary of the INO Midwives' Section (2009)

Bridget Sheeran, (Cliona McLoughlin), Elke Hasner and Sally Millar are Chair, (incoming Chair), Treasurer and Secretary of the Community Midwives Association (CMA) 2009

Appendix Three
Informed Consent Documentation

Information Sheet for Midwives

Title of study: An Ethnography of Independent Midwifery in Ireland

Introduction: I would like to invite you to participate in a research study on independent midwifery practice in Ireland. I am a qualified midwife and midwife teacher but new to independent practice. I believe that independent midwifery and homebirth are realistic alternatives to hospital based care. There are very few independent midwives in Ireland and a study into what it is like to be an independent midwife will tell other midwives about independent practice as an alternative to hospital practice. Information gathered will also inform maternity hospitals and health service planners in decision making about maternity service options beyond the hospital based model. It is intended that my own experience of becoming an independent midwife will provide personal autobiographical data. Participation in and observation of the lives of independent midwives will form the greater part of the data. This information sheet is designed to enable you to decide whether you want to participate.

Procedure

There are several aspects to the design that need to be considered and they are presented below.

Part 1

I would like to get a full picture of how independent midwives work and what it is like to be an independent midwife. The study will be based upon my observations while working with independent midwives and as an independent midwife. The study is also based upon talking with independent midwives. These conversations are not formal, they arise from questions and a search for explanations as things happen in real situations. I am asking for your permission to be with you while you, the independent midwife, carry out all aspects of your role. I am asking your permission to write down what I see, hear and interpret about the real life of independent midwifery practice. This process is called participant observation and would happen at times convenient to you over a period of one to six months. This may seem like a considerable commitment but ongoing consent will be sought and you are free to withdraw or decline to participate at any point.

Part 2

A second significant element of data collection will involve one or more tape recorded unstructured interviews where you are invited to talk freely of your experience as an independent midwife focussing on whatever areas of your experience or practice you feel most significant to increase understanding of the independent midwife. You will be given access to the transcripts of your interviews. A separate consent form is proposed to formally record your willingness to participate in these interviews. You may decide that you would like to provide information about your role, your life history or stories from your experience, in written form, as well as, or instead of, audio-taped interview. I would, with your consent, use some or any part of such writings in my own presentation of the research. I cannot however offer editing rights to any participant.

Part 3

A further issue about consent that needs to be considered is gaining permission to be with you in women's homes as you work. I enclose an information sheet and consent form that I would ask you to offer to your clients so that I might accompany you during your work with these women. You are effectively acting as a gatekeeper to ensure that women are fully informed and consent to my presence in their homes.

As you can see there are several things to which you are being asked to consent. In brief they are 1) to be observed and asked about your practice over a prolonged period, 2) to participate in audio-taped interview and 3) to seek permission from women in your care for me to observe you at work in their homes

Benefits

There are no direct benefits to your participating in this study except that I will be another midwife at hand who is able and willing to participate in the giving of midwifery care, advice and support. This may range from no participation to full participation as each situation dictates and as negotiated by each person involved.

Risks

There should be no risks, other than the potential for inconvenience, due to my participation or observation during data collection. I am a qualified and accountable professional and am bound by the An Bord Altranais code of professional conduct in all my actions.

Confidentiality

Your identity will remain anonymous and details about you confidential. Your name will not be recorded in my diary or field notes. Any identifying features will be removed before publication of research findings. Field notes will be kept on my person at all times and any records or diary material will be stored in a secure place.

Compensation

You will receive no compensation or payment for participation in this study. Research data collection is covered by standard institutional indemnity insurance. Nothing in this document restricts or curtails your rights.

Voluntary participation

If you agree to participate in this study you will be asked to sign a consent form indicating your willingness. Your participation is entirely voluntary; you are under no obligation to participate. You may withdraw at any time without question.

Permission

The research aspect of the proposed study has received ethical approval from The University of Dublin, Trinity College, Faculty of Health Sciences, Research and Ethics Committee.

Further information

Thanks you for taking time to read this information sheet.

If you have any questions about this study, about your rights as a participant or wish to clarify any aspects I am happy to meet with you to discuss them further.

Colm OBoyle 00 353 1 6083923 coboyle@tcd.ie

Midwife's Informed Consent to Participant Observation

An Ethnography of Independent Midwifery in Ireland

by Colm OBoyle

Background

The purpose of this study is to study the lived experience of independent midwives by documenting all aspects of my own experience of becoming an independent midwife and by observing and participating in the experiences of other independent midwives in all aspects of their role. It is hoped that a better understanding of the experience of independent midwifery practice might lead to increased recognition of its worth in the wider maternity services.

The study has been approved by University of Dublin Trinity College School of Nursing and Midwifery and Faculty of Health Sciences, Research and Ethics committees and involves no foreseeable harm to you.

Procedure

The researcher will be actively observing and noting all aspects of the actions, speech and environment in which independent midwives work. These will be recorded in field notes at the time and written out in full as soon as possible thereafter, including quotations where possible. The researcher strives not to interrupt the behaviours but will probably ask you to explain how you see various aspects of the actions. You may be asked to describe how you feel during and after any activity. You may freely choose not to answer any questions or to withhold the right to have any of your actions recorded as part of the study even while continuing to participate.

You may wish to share your views on aspects of independent midwifery practice in the form of writings or journals that you allow me to see. I could, with your consent, use some or any part of such writings in my own retelling of the story. I cannot however offer editing rights to any participant.

The field notes will be kept on my person at all times and any other notes and diaries will be kept in a secure place not shared with others. No records will show names and all identifying features will be removed in any publication.

Your participation is completely voluntary, you are under no obligation to participate and you may withdraw, at any time. Any contact between you and I will be with your verbal consent on an ongoing basis.

Consent for formal audio-taped interview will be obtained separately. You are asked to request consent for the researcher to accompany you while giving care to women. Your judgement as to the appropriateness of this access is respected. Information to women and their consent form are attached for your inspection.

Declaration

I have read this consent form. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study and to act as gatekeeper to obtain consent to access clients' homes. I understand that this does not affect any ethical and legal rights I have. I understand I may withdraw from this study at any time. I have received a copy of this agreement.

Participant's Name

Participant's Signature

Date

Statement of investigators responsibility:

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions. I believe that the participant understands my explanation and has freely given consent.

Investigator's signature

Date

Midwife's Informed Consent to Audio-taped Interview

An Ethnography of Independent Midwifery in Ireland

by Colm OBoyle

Background

The purpose of this study is to study the real lived experience of independent midwives by documenting all aspects of my own experience of becoming an independent midwife and by observing and participating in the experiences of other independent midwives in all aspects of their role. It is hoped that a better understanding of the experience of independent midwifery practice might lead to increased recognition of its worth in the wider maternity services.

The study has been approved by University of Dublin, Trinity College, Faculty of Health Sciences, Research and Ethics Committee and involves no foreseeable harm to you.

Procedure

As part of the data collection for this study you have been invited to participate in an audio-taped interview. The interview will take place at a place and time convenient to you. The interview duration depends entirely on you. It is unstructured; that is, you are invited to speak freely about your life as an independent midwife. You might for example decide to describe how you came to practice independently, to highlight those issues that most affect your freedom to practice, or perhaps discuss any concerns, dilemmas, joys or satisfaction the role may bring. It would be unusual for any one interview to take more than 1 ½ hours. You may want to record further thoughts in subsequent interviews.

Your participation in this interview is entirely voluntary. You will be given access to the transcripts of your interviews. If you wish, I will share with you the themes I have identified from your interview and you may wish to expand upon or comment on those themes or my interpretation in a further interview.

Declaration

I have read this consent form. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study. I understand that this does not affect any ethical and legal rights I have. I understand I may withdraw from this study at any time. I have received a copy of this agreement.

Participant's Name

Participant's Signature

Date

Statement of investigators responsibility:

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions. I believe that the participant understands my explanation and has freely given consent.

Investigator's signature

Date

Information sheet explaining the study and requesting access to the woman's home

An Ethnography of Independent Midwifery in Ireland

by Colm OBoyle

Introduction: I am a midwife studying what it is like to practice midwifery independently. I am writing about what it is like to become an independent midwife myself and I am following other independent midwives, asking them questions and watching them as they work.

To do this study I really need to see how independent midwives work in the homes of the women they work with. I have to ask for your permission and have your consent before I can enter your home to do this. This information sheet is designed to help you to decide whether you want to take part in this study by allowing me to observe your midwife as she provides care to you and your family

Procedure

I will be watching and noting everything about how and where the midwife works and what she says. The main focus is on the midwife but I may ask you to describe how you feel during the visit. You may freely choose not to answer any of my questions. You may ask me to leave the room or your house at any time or for any part of the midwife's visit. My notes will be kept on my person at all times and any other notes and diaries will be kept in a secure place not shared with others. No records will show names and all recognisable details will be removed in any publication.

Your taking part is completely voluntary, you do not have to let me into your home or speak to me and you may withdraw, at any time. Any contact between you and I will be with your verbal consent on an ongoing basis.

Benefits

There are no direct benefits to you in taking part in this study except that I will be another midwife at hand who is able and willing to give midwifery care, advice and support but only as little or as much as you want.

Risks

There are no risks to you from my study, If my presence becomes inconvenient you may ask me to leave and I will do so. I am a qualified and accountable professional and am bound by the An Bord Altranais (the regulatory body for nurses and midwives) code of professional conduct in all my actions.

Confidentiality

Your identity will be anonymous. Your name will not be recorded in my diary or field notes. Any identifying features will be removed before publication of the research findings. Study notes will be kept on my person at all times and any records or diary material will be stored in a secure place.

Compensation

You will receive no compensation or payment for participation in this study.
Your rights are unaffected by participation in the study.

Voluntary participation

If you agree to take part in this study you will be asked to sign a consent form saying so. You do not have to take part and you may decide to stop at any time without question. Withdrawal from the research will in no way effect the care being offered to you by your midwife.

Permission

The research aspect of the proposed study has received ethical approval from The University of Dublin, Trinity College, Faculty of Health Research and Ethics Committee.

Further information

Thanks you for taking time to read this information sheet.

If you have any questions about this study, about your rights as a participant or wish to clarify any aspects I am happy to meet with you to discuss them further.

Colm OBoyle 00 353 1 6083923 coboyle@tcd.ie

Woman's consent to have the researcher accompany her midwife during care episodes in her home.

An Ethnography of Independent Midwifery in Ireland

by Colm OBoyle

Background

The purpose of this study is to study the lived experience of independent midwives by documenting aspects of my own experience of becoming an independent midwife and by observing and participating in the experiences of other independent midwives in all aspects of their role. It is hoped that a better understanding of the experience of independent midwifery practice might lead to increased recognition of its worth in the wider maternity services.

The study has been approved by University of Dublin, Trinity College, Faculty of Health Research and Ethics Committee and involves no foreseeable harm to you.

Procedure

The researcher will accompany your midwife into your home. The purpose is to observe and document the midwife's role and interactions as she works. The researcher will only accompany the midwife when and if you have given your consent. Initially this will be by this consent form but at any and every visit you will be asked verbally if you are happy to consent to the researcher's ongoing presence.

There are no direct benefits to you in taking part in this study. Withdrawal from the research will in no way effect the care being offered to you by your midwife.

Your identity will remain confidential. Your name will not be recorded in my diary or notes. Any identifying features will be removed before publication of research findings. Notes will be kept on my person at all times and any records or diary material will be stored in a secure place.

Declaration

I have read this consent form. I have been given the opportunity to ask questions and all my questions have been answered to my satisfaction. I freely and voluntarily agree to be part of this research study, to allow the researcher into my home only when accompanying my midwife. I understand that this does not affect any ethical and legal rights I have. I understand I may withdraw from this study at any time. I have received a copy of this agreement.

Participant's Name

Participant's Signature

Date

Statement of investigators responsibility:

I have explained the nature and purpose of this research study, the procedures to be undertaken and any risks that may be involved. I have offered to answer any questions and have fully answered such questions. I have offered to give the researcher's contact details for further clarification if needed. I believe that the participant understands my explanation and has freely given consent.

Midwife's signature

Date

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