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The Culture of Birth in Ireland at the
Interface Between Home and Hospital: An
Ethnographic Study of In-labour Transfer to
Hospital During Planned Home Birth

Thesis submitted in fulfilment of the requirement for
the Degree of Doctor of Philosophy at the
University of Dublin Trinity College

2015

Linda Biesty

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Summary

Background: Birth is not just a physiological process but also a significant life event embedded in historical, political and socio-cultural constructions. These constructions of birth have a profound influence on the provision of maternity services, maternity practices (midwifery and obstetrics) and on women's experiences. The cultural understanding of birth in Ireland places maternity care, for the most part, in centralised maternity hospitals focused on obstetrical-led, medical-based care. Women looking outside this model have few options available, midwife-led models of care are not well developed and the Health Services Executive does not have a legal obligation to meet women's needs in relation to place of birth. Women who choose an alternative to hospital birth, (for example, home birth) are stepping outside the conventional model of care. These women (and the midwives supporting them) demonstrate that they view birth as a normal process that does not result in them needing hospital-based medical surveillance and intervention.

There is a dearth of information relating to the meeting of these two understandings of birth and the experiences of women who plan a home birth but transfer to hospital during their labour. Specific issues within the organisation of maternity care and the culture of birth in Ireland remain unknown. This study was designed to address this deficit by exploring the experiences of women when these two ideologies / cultures converge at the intense time of in-labour transfer to hospital during planned home birth. To provide an in-depth exploration of the interface between home and hospital birth the accounts and experiences of healthcare providers¹ were also included.

Aim: To explore and understand the culture of birth in Ireland at the interface between home and hospital, as experienced during in-labour transfer to hospital during planned home birth, from the viewpoint of all key stakeholders.

¹ Self Employed Community Midwives (SECMs), hospital midwives (HMWs) and obstetricians

Methodology: A critical ethnographic approach provided the appropriate framework to meet the aims of this study. Ethical approval was granted by the Faculty of Health Sciences at Trinity College Dublin and three research sites. Data were gathered using participant observation and in-depth interviews across participant groups at relevant stages of women's pregnancy, birth and after experiences of transfer. Thirty-two episodes of antenatal care between pregnant women (n=23), and SECMs (n=6) were observed. Observation of ten home births contributed to the data. Eight women birthed at home, two experienced in-labour transfer to hospital and one woman transferred to hospital immediately after the birth of her baby. Interviews were conducted with women who experienced a transfer from home to hospital during labour (n=25), SECMs (n=15), hospital midwives (n=17) and obstetricians (n=4). Data were analysed using the Voice-Centred Relational Method. This enabled an exploration of the participant's experiences in relation to their interactions with others and the broader social and cultural contexts in which their experiences occurred.

Findings: The findings of this study juxtapose experiences where there was a seamless interface between home and hospital birth with interactions played out against a background of suspicion; narratives of safety and risk, power and trust intertwined and underpinned the encounters. Four global themes emerged from the data – Women: *'from my space to their place'*, SECMs: *'negotiating a space in-between'*, HMWs: *'inhabiting a contested space'*, obstetricians: *'occupying a confident space'*.

Conclusion: This ethnography indicates the extent to which home birth, in Ireland, is a contested issue. Debates in relation to place of birth and protocols and procedures guiding care are exemplified during transfer from home to hospital. This study has brought into focus how the current maternity service continues to apply the dominant discourse of obstetric readings of risk in the provision of maternity care. The findings demonstrate the various manoeuvres whereby women and SECMs attempt to negotiate this dominant discourse, and yet the status quo remains.

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My time now belongs to my long-eye-lashed, blue-eyed boys – my amazing husband Stephen and our beautiful sons Luke and Sam. For putting up with my absences and giving me space (sometimes grudgingly!) to complete my ‘*homework*’. Stephen, for believing in me and in this study during my moments of doubt, I thank you, *le grá go deo*.

Dedication

I dedicate this PhD thesis to my boys, Stephen, Luke & Sam.

And to the memory of two very different, yet equally amazing women:

Anne Marie O'Loughlin (1974 - 2000)

and Lorraine Andrews (1964 - 2013).

Anne Marie and Lorraine taught me how to be myself, believe in myself
and stand up for myself.

Ye are missed.

Start where you are.

Use what you have.

Do what you can.

Arthur Ashe

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List of Abbreviations

ABA	An Bord Altranais (until 2012)
AIMS (Ireland)	Association for Improvements in Maternity Services
CIS	Clinical Indemnity Scheme
CMA	Community Midwives Association
CMM	Clinical Midwifery Manager
CTG	Cardiotocograph
DoH	Department of Health (until July 1997)
DoH&C	Department of Health & Children (from July 1997)
DOMINO	Domiciliary In and Out
ECV	External Cephalic Version
ESRI	Economic and Social Research Institute
GP	General Practitioner
HBA	Home Birth Association
HMW	Hospital Midwife
HSE	Health Services Executive
ICM	International Confederation of Midwives
IOL	Induction of Labour
INMO	Irish Nurses & Midwives Organisation
KPMG	Klynveld Peat Marwick Goerdeler
MICS	Mother and Infant Care Scheme
MLU	Midwifery-Led Unit
MOU	Memorandum of Understanding
NHS	National Health Service, UK
NICE	National Institute for Health and Care Excellence
NMBI	Nursing & Midwifery Board of Ireland (from 2012)
NMH	National Maternity Hospital
Obs	Obstetrician
RCM	Royal College of Midwives
RCOG	Royal College of Obstetricians & Gynaecologists
SECM	Self Employed Community Midwife
VCRM	Voice-Centered Relational Method
VE	Vaginal Examination

Glossary of Terms

An Bord Altranais agus Cnáimhseachais na hÉireann	Nursing & Midwifery Board of Ireland (from 2012)
An Bord Altranais	Nursing Board of Ireland (until 2012)
Cuidiú	The Irish Childbirth Trust
In-Labour Transfer	The transfer, of a woman who has planned a home birth (with a Self Employed Community Midwife) from home to hospital during her labour
Plámás	To Cajole
The ICM Definition of a Midwife	This definition has been the internationally accepted standard since 1974 The current definition was revised and adapted by the ICM Council in 2011: <i>“A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to competency in the practice of midwifery.”</i>

Chapter One: An Overview of the Thesis

1.1 Introduction

This thesis brings together questions of the culture of birth in Ireland through an exploration of the interface between home and hospital. Birth is a cultural as well as a biological matter and is embedded in complex and competing medical, historical, political and sociocultural discourses (Jordan 1993). These discourses have a profound impact on the kind of care that women will receive and the manner in which the maternity services are organised. As a result of cultural and historical shifts in the understanding of birth, women in Ireland experience birth in the context of a maternity system which supports obstetric-led, hospital-based care in the main (Devane et al 2007); a maternity service that has been described as medicalised, centralised and highly interventionist (Daly & OBoyle 2010, p. 15). Davis-Floyd (1992) terms this *the technocratic model*² of birth, which assumes the body as a machine in need of medical surveillance and intervention to function correctly. In this understanding birth is held as inherently risky, requiring the management of skilled medical practitioners – experts, for its success (Lupton 1999). Jordan (1993) holds the medical community responsible for convincing women that best practice in childbirth is located in a medically managed model. In this approach the knowledge of the health care professional is deemed to hold the authoritative voice (Murphy-Lawless 1998). Women have lost charge over their bodies and how to give birth, as control and responsibility are taken over by medical routines now viewed as the standard of best practice (Davis-Floyd & Cheyney 2009). This is held in contrast to the *social model* of birth that is based on the philosophy that birth is a normal life event and should, therefore, be positioned within a social rather than a medical model (Pairman & McAra-Couper 2005). The physical, psychological, social, cultural and spiritual needs of women are the focus (Daellenbach & Edwards 2011) and women value a different understating of birth that is not located in medical management and intervention (Cheyney 2008).

² Midwives and women in Ireland label this the medical model.

In spite of the attempts of the medical discourse to assign their particular beliefs as the *true* version of birth, there remains a cohort of women and of midwives who believe that they are able to accomplish pregnancy and birth without any obstetric intervention and eschew the dominant discourses of childbirth. In order to seek viable alternatives to hospital-based care, women go outside the dominant medical model of birth. For women in Ireland seeking an alternative to obstetric-led care, few choices are available. Only two midwifery-led units exist in the country. Schemes providing a home birth service as part of hospital outreach services are currently on offer in only two regions. Whilst some maternity hospitals provide midwife-led antenatal clinics, DOMINO and early-transfer-home-schemes, these are not offered nationally (Murphy-Lawless 2011). Access to these schemes is limited by catchment parameters and strict inclusion criteria. Women planning a home birth (outwith the aforementioned schemes) must personally seek a Self Employed Community Midwife (SECM) of which there are only 15 nationally³. The legislation in relation to the provision of services for maternity care in Ireland is contained in the Health Act (Government of Ireland 1970). Section 62 (1) offers a legal framework for women to seek home birth services from the health board –

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

However, when the compliance of a health board to this statutory requirement was challenged by four women seeking home birth, a Supreme Court decision ruled the State’s obligation to provide maternity care is fulfilled if maternity services are offered within the confines of a hospital [O’Brien Vs South Western Health Board 2003 and others⁴]. As a result it would appear that all women in Ireland have access to publically funded maternity services; however, this does not constitute a choice in relation to place of birth. As such, the dominance of the medical model of birth and the

³ Community Midwives Association (CMA), personal communication, February 2015.

⁴ O’Brien v South Western Health Board, Brannick v East Coast Area Health Board, Clarke v South Western Area Health Board, Lockhart v South Western Area Health Board. [2003]

hegemony of obstetrics are maintained and reinforced. It is in this context that this study is being undertaken.

In 2012, 176 women birthed at home with the support of a SECM, this represents 0.2% of all births (Economic and Social Research Institute (ESRI) 2013). Reasons why women choose home birth in Ireland, and choose to depart what is culturally the dominant place of birth, remain unknown. Drawing from reviews of the maternity service and the international literature it is suggested that for the most part, women choose home birth because they are concerned with the medically managed labour associated with hospital birth and with maintaining control of their experience (Cheyney 2008). Place of birth remains a contested notion in Ireland in spite of evidence that supports home birth with a midwife, within an integrated maternity service with adequate referral processes, as a safe choice for women experiencing a physiological pregnancy (Brocklehurst et al 2011). The Birthplace in England Study (Brocklehurst et al 2011), has led the debate in relation to place of birth and the provision for sustainable models of care that give choice to women. In December 2014 the recommendations of the study for planning place of birth were incorporated into the National Institute for Health and Care Excellence (NICE) guideline for intrapartum care (NICE 2014). The Birthplace Study also drew attention to an in-labour transfer to hospital rate of 21% (45% primiparous women, 12% multiparous). The most recent publically available figures in Ireland show a 15% intrapartum transfer rate for women who planned to birth at home (Meaney et al 2013). It is during this time of transfer that the differing paradigms of birth, the ideologies of home and hospital birth meet. This is where the interest of this study lies.

1.2 Locating the Public Debate on Home Birth in 21st Century Ireland

This research took place at a time when the differing paradigms of understanding around home birth were projected into the Irish media. Fueled by 3 legal cases (two occurred during the Summer months of 2013 and one in April 2014), the topic of home versus hospital birth received extensive coverage, which kindled a renewed interest in the *“home birth fires ... keeping both opponents and proponents nicely warm”* as

originally coined by Keirse (2010, p. 341). This public deliberation by health care professionals and users of the maternity service brought to the fore discussions of safety in planned home birth.

On the 31st July 2013 the landmark High Court case taken by Aja Teehan [Teehan V the Health Service Executive (HSE) and the Minister for Health 2013] commenced. This judicial review was initiated during Aja's second pregnancy; her first child – (a daughter, age 6) was born by caesarian section. Aja's history of a caesarian section precluded her from accessing a home birth under the Health Service Executive (HSE) criteria set out in the Memorandum of Understanding (MOU)⁵. Her legal challenge sought to compel the HSE to engage in a process to assess her and indeed all women on an individual basis rather than their administration of a 'blanket policy' in relation to the suitability of women for a home birth (Teehan 2013a). The judgment issued on 16th August by Ms Justice O'Malley rejected the application, stating that it would be "*manifest irrationality for the courts to change the criteria for home births as set out by the HSE*" (McGreevy 2013). The court upheld the Irish Supreme Court ruling [O'Brien v South Western Area Health Board 2003] that "*there was no statutory obligation on the HSE to provide for a home birth service*". In September 2013 it was reported that Ms. Teehan and her family moved to a country that did not prohibit her from receiving midwifery care in the community and planning a home birth (Teehan 2013b).

The two day inquest into the death of a baby who was stillborn was the second legal case that stimulated national interest around birth. In May 2011 Kai David Williams Henaghan was stillborn following the in-labour transfer of his mother to hospital by a Self Employed Community Midwife (SECM), during the second stage of her labour. The planned home birth "*was abandoned when the fetal heart began to diminish*" (Shiel 2013a). On 10th September 2013 the coroner recorded a verdict of death by misadventure and in his recommendations focused on *safety* issues, as he saw them,

⁵ The Memorandum of Understanding (MOU) is an agreement between the Health Services Executive (HSE) and SECM, Section 4.5 and Appendix 1. Clinical indemnification for home birth midwifery is achieved via the States Claims Agency Clinical Indemnity Scheme and facilitated if SECMs sign an MOU and practise within the guidelines therein.

surrounding home birth. He recommended that – 1) two midwives should attend every home birth; 2) the emergency services should be on standby when a woman who has planned a home birth is in labour and 3) that the geographical distance from the home to a hospital must be taken into consideration when undertaking a risk assessment before a home birth is planned (Shiel 2013b).

The extensive coverage given to these two cases by the country's media led to a televised "*home versus hospital*" debate where 'experts' were called upon to offer their opinions.⁶ The discussion, debate and sound bites featured in the local and national media, centered on safety. Questions were asked, such as: '*is home birth safe, is hospital birth safer, who should be 'allowed' to birth at home, who should not be 'allowed' a home birth, who should be present at birth ...?*' The answers offered by the "experts" in the television studio, and contributions from the audience, highlighted the tensions that exist in relation to birth outside hospital. Beliefs about birth, at this specific time in Ireland and against this particular backdrop demonstrated the wide gulf between the principle of birth being a *normal physiological event* and the principle of birth as *only normal in retrospect*, with little attention to bridging this disconnect. While the *home versus hospital* debate continued, birth activists despaired that this public examination of the 'issues' did not lend itself to a true (and needed) critique of the maternity service (AIMS 2013). Instead, they believed that polarised views in relation to risk and safety marked the discourses of birth played out in the public arena (Kryisia Lynch, AIMS and Home Birth Association, September 2013) This interest did little to move *opponents and proponents* of home birth toward a shared frame of reference. It did, however, make explicit the cultural divide between home and hospital birth that has become embedded in the maternity services in Ireland.

Discourses surrounding the safety of home birth emerged in the media and public arena in 2014. On 30th April 2014 it was reported that the HSE temporarily suspended the professional indemnity insurance held by one of the SECMs (Philomena Canning) on pending an investigation into "two

⁶ "Prime Time", RTE 1, 17th September 2013.

serious incidents” regarding the transfer of women to hospital from home birth (Bray 2014). Both women, and the SECM, publically refuted these claims (McGreevy 2014). The case became the subject of proceedings in the High Court when the SECM was unsuccessful in having the withdrawal reversed (McGreevy 2014). In October 2014 media reports stated that over 200 women presented the Health Minister with a 2,500 name petition demanding that he intervene (Bray 2014). On the 25th February 2015, two days before a scheduled hearing of the Supreme Court Appeal (taken by the SECM), the indemnity insurance was reinstated. The media reported that solicitors for the HSE said “*necessary foundation no longer exists for temporary suspension*” (Cullen 2015). While an independent review of this case has not been undertaken, none-the-less I think it would be remiss if I did not include reference to highlight the ongoing disquiet in relation to home birth in Ireland.

I am very aware that media sources do not provide a complete picture of the issues; however, I think it important to provide as much insight as possible to the cultural context of this study. The public debate has drawn attention to the dichotomy of views in relation to home birth; this study was undertaken to examine some of the issues in-depth and provide an ethnographic insight into the experiences during transfer.

1.3 Overview of the Study

Locating birth is a complex issue and to do so requires focusing not only on women but also those who make decisions regarding the kind of care that women will receive and the manner in which the maternity services are organised. Throughout this study I sought to address the scarcity of women’s voices in relation to home birth in Ireland, to develop an understanding of their immediate experiences and the broader socio-cultural issues that influenced their in-labour transfer to hospital. As these experiences are shared with healthcare providers, the inclusion of their accounts was necessary to provide an ethnographic exploration of the interface between home and hospital birth in Ireland as experienced at in-labour transfer.

1.4 Aim and Objectives of the Study

To explore and understand the culture of birth in Ireland at the interface between home and hospital, as experienced during in-labour transfer to hospital during planned home birth, from the viewpoint of all key stakeholders.

Objectives:

1. to observe antenatal discussions surrounding labour, birth and transfer between women planning a home birth and the SECM offering them care - to explore the meaning they place on possible in-labour transfer to hospital
2. to observe home birth and be present at in-labour transfer to hospital - to become immersed in the culture of home birth in Ireland and explore the decision-making, communication and interactions of key stakeholders during their experiences
3. to explore with women their experiences of in-labour transfer to hospital during planned home birth
4. to explore with SECMs their experiences of in-labour transfer to hospital during planned home birth
5. to explore with hospital-based midwives their views of home birth and in-labour transfer, based on their experiences
6. to explore with obstetricians their views of home birth and in-labour transfer, based on their experiences

1.5 Structure of the Thesis

This study explores the culture of birth in Ireland in the context of in-labour transfer to hospital during planned home birth. I will bring the reader on my research journey from my story, through a description of birth practices nationally (and some internationally), to the stories of women, self-employed community midwives and hospital-based clinicians in contemporary Ireland. To do this I have organised the thesis into the following chapters:

Chapter one presents an introduction to the study. A brief overview of home birth in Ireland is given and the initial rationale for the study is provided.

Chapter two provides an autobiographical account of the personal and professional context that informed this study, thus positioning me as the researcher. It also addresses my questions about the interface between home and hospital birth in Ireland, and the significance of these questions. I identify the critical gap in the empirical knowledge in relation to the interface of home and hospital at the time of in-labour transfer, and outline the aim of this study.

Chapter three provides an overview of birth in the Western world and changes in the cultural understanding of birth that has emerged since the Enlightenment era. Specific reference is made to historical events that have impacted on the views of birth, the professional role of obstetrician and midwives and place of birth as a cultural phenomenon in Ireland today. This historical and cultural critique and discussion further illuminates the ethnographic setting and provides context for the questions I explore in the subsequent chapters.

Chapter four continues to explore issues surrounding place of birth, and reviews the dominant discourses that have influenced the current provision of maternity care in Ireland.

Chapter five provides the research design underpinning the ethnographic framework of this study, highlighting how the design emerged and its appropriateness in the context of this study. In this chapter I examine my assumptions that underline the methodological choice.

Chapter six details the application of the research design from methodology to methods including participant-observations and interviews. In this chapter I describe the research sites and highlight some of the challenges associated with a multi-sited ethnography with the added complication of the unpredictability of the onset of labour. I explore my

position as a researcher and a midwife (at home birth) rather than a neutral observer and outline how this influenced my position in the research field. I also address a number of ethical issues arising in an ethnographic study.

Chapters seven and eight present the findings of this study through ethnographic description of the participant's construction of birth and through the identification of cultural themes which are supported by extracts from the raw data. I explore the construction of home birth through the participant's narratives, the stories and experiences of women, midwives and obstetricians. Through an examination of narratives and observational data I identify how women and healthcare professionals negotiate their different perceptions of birth and how this impacts on their interactions during transfer. The findings juxtaposed experiences where there was a seamless interface between home and hospital birth with interactions played out against a background of suspicion, where narratives of safety and risk, power and trust are intertwined and underpin the encounters.

Chapter nine concludes this thesis and presents the key findings and issues raised in this ethnographic study. This chapter presents a detailed discussion employing empirical and theoretical insights drawn from discourses of power, risk and trust to illuminate the cultural themes identified in the study. I claim this thesis as a critical ethnography in that it reveals new stories in relation to the culture of birth that challenge the dominant discourse and the current organisation of care. I believe that identifying new narratives in this context is both a scholarly endeavour and a political act in that emerging from this thesis are recommendations for models of maternity care in Ireland including areas for future research.

Chapter Two: Background to the Study

2.1 Introduction

In this chapter, I provide an overview to my rationale for undertaking an ethnographic study of in-labour transfer to hospital during planned home birth. I will address my questions about the interface between home and hospital birth in Ireland and the significance of these questions. I will outline the aim and objectives of this study. This will provide insights into the origins of the study, and the choices of research methodology and methods, thus framing and supporting the findings and discussion drawn from the study. In keeping with the ethnographic tradition, I will use the first person voice as I locate my experiences of birth and midwifery within this research.

From the inception of the study as a potential project, through to completion I have reflected [and continue to reflect] on my position as a mother, a midwife, and lecturer in midwifery and the influence of my status as both *insider and outsider*. While I considered that I was conscious of my *multiple positions* at the preparatory phases of this study, I became more aware of the multiple voices that emerged during fieldwork, and my multiple 'hats'. I examined my varying status as an *insider* and an *outsider* (and sometimes I was both an insider and outsider) at all stages of the research process and the implication that this had on the study; this is evident in the extracts from my research diary that are shared at relevant points within this thesis and also in the way the Voice Centred Relational Method (VCRM) (Mauthner & Doucet 1998) guides my interpretation of the data (See Chapters 5 & 6).

These hats that I speak of place me in a position where I have lived, and continue to live, in different relationships with participants of this ethnography. My biography is clearly intertwined with the stories of this research and I am thus in a unique position to tell this ethnography of in-labour transfer to hospital during a planned home birth. I relate to the experiences of the women who participated in this research. I planned a home birth, supported by Self Employed Community Midwives (SECMs); I

experienced an in-labour transfer and I birthed my baby in a hospital. I am a midwife; I have practised within different models of maternity care including tertiary referral maternity hospitals experiencing caring for women experiencing highly technological, high intervention birth, as well as normal birth. During the course of this study I became an SECM. I needed to be in a position to support the midwives and women during birth should the need arise. In order to gain access (to *get in*, in ethnographic terms) and be present in an ethical way in keeping with my professional registration I needed to be an SECM. I am a researcher who is an outsider but a professional insider as well. I signed an MOU, I did the on-calls, I was there. In the words of the renowned organisational ethnographer John van Maanen - *I hung out with them, I got in there and did it* (Personal Communication van Maanen 2012) and I saw what it was like. I saw the relationships, the interactions, the ongoing connection between midwife and family long after the event of birth. I saw what is central to the culture of home birth. I am also a lecturer in midwifery. I am aware of and engage with the research literature and social policy in relation to birth. I understand how, and from where, the knowledge and views in relation to birth and place of birth have emerged, and how they affect maternity services and women's experiences.

I consider it vital that I acknowledge my own personal and professional knowledge and experiences, without which I question if I could have undertaken this specific study. I explore my personal experience as a woman who experienced an in-labour transfer to hospital during a planned home birth, my professional positions as a midwife and lecturer in midwifery, to highlight how these experiences inform my thinking. Ethnography enabled me to identify which perspective is influencing my interpretation at a particular time and make sense of my own story in the context of other women's stories, and our stories in the context of the literature. Ethnography also allowed me to acknowledge my identity as a midwife in terms of an SECM, a hospital-based midwife and that of a lecturer in midwifery and my role in informing and developing the profession of midwifery into the future.

2.2 Where it all Began – My Personal Story

This study was conceived in the year after the birth of my first son (he was born in November 2007). As a midwife and a lecturer I have a particular experience and view in relation to birth, but it was as a pregnant woman that I decided I would like a home birth. So I planned a home birth. Why a home birth particularly? Was it something that I had always wanted? – I'm not sure; I know I never actively did not want a home birth, but from the moment I realised I was pregnant it was most definitely what I wanted. Why? I know birth in Ireland, I know birth within the large, overcrowded hospitals where deviations from the normal are expected and interventions are at the ready, and this experience I did not want. I believed that my body was made for this; that birth is normal and I wanted to be surrounded by others who supported normality. I wanted midwives who would provide the emotional care that I thought important; I wanted to be cared for and not have the caring experience interrupted by beeping machines or the needs of the service or routines that were not based in evidence or necessity. I did not want any interference with the emotional and physiological happenings of my body and my pregnancy unless there was a very good reason. I wanted to be known to my midwives but likewise I wanted them to be known to me. I wanted people with me who knew me and knew what I believed in, thought and wanted. I did not want to meet a different midwife at every hospital visit, making pleasantries in an attempt to engage about this very important event that was going on in my life. I wanted to know my midwives, their thoughts, beliefs and experiences. I did not want to be my own midwife during my pregnancy and especially not during my labour – I wanted to focus solely on myself while my midwives did what they do best – supporting and caring for me during labour.

I also considered it *time to put my money where my mouth was*. I had spent years talking about birth, supporting physiological birth, challenging routine intervention; I had spent years talking about midwifery and midwives. Now was the time to demonstrate that my personal beliefs mirrored my professional rhetoric. So I *chose* my midwives. In Biesty (2012) I refer to the unique position that I was in, as a midwife, in that I had choices that I know were not available to all women in Ireland at this time. I chose my

midwives, two of my best friends, two midwives who have a wealth of knowledge and experience, the people I wanted to be there with me. I was so happy and so comfortable and so excited. My antenatal care and planning for labour was organised around me and all was good.

I contacted the maternity hospital nearest to my home and informed them that I was having a home birth. The Director of Midwifery and Director of Obstetrics both wrote to me acknowledging my choice and wishing me the very best of luck. Their doors were always open to me to me if I needed them. It must be noted that this occurred at a time when the ‘Masters’⁷ of the three Dublin maternity hospitals had withdrawn access to haematology and ultrasound services for women planning a home birth. OBoyle’s ethnography of independent midwifery in Ireland highlights the challenges this presented to SECMs and to women planning a home birth during this time (OBoyle 2009). This unexplained, unilateral withdrawal of services was also held as responsible for reinforcing a ‘*them and us*’ type mentality of opposition between home and hospital birth and did little for relationships between health care practitioners and women (Murphy-Lawless 1998). But I experienced no such hostility, no such limitation of the services available to me. Again this is perhaps as a result of my unique position; I had ‘done my time’ as a hospital-based midwife, I was a lecturer in midwifery, I was ‘known’.

In a way I was able to make my model of maternity care suit my specific needs. The model of care I chose merged all things I believe to be important in relation to maternity care. I had chosen my midwives because of their expertise and skills. I knew the care they would provide would not just focus on my physical needs and the wellbeing of my baby but also on the emotional support I would need. As a midwife and a lecturer I was aware of the cultural changes that occurred as a result of the medicalisation of birth and how these changes, made in the name of safety, changed the landscape in which women traditionally birthed. I was aware that I was choosing to

⁷ Title used to denote the clinical lead in the three Dublin maternity hospitals. Although it remains as ‘master’ it is not a gender specific post, in fact two of the current ‘masters’ are female.

birth in a traditional environment without the modern technologies associated with hospital birth; however I was also confident in the skill and expertise of my midwives, and I knew I would feel safe and cared for in their care. I do not believe that these beliefs and feelings I hold are mutually exclusive.

So we prepared for labour, for this home birth that I was going to have. My environment – I didn't fuss much. As long as I had room to move around and the birthing pool fitted I was grand. I am not a bath person, but yet towards the end of pregnancy this was the only place I truly felt comfortable, so a birthing pool made sense to me. The room was not my focus it was the people in it. Colours, lights, smells, noise – the stuff I had heard women talking about at home birth meetings, on fora in relation to natural birth - I didn't think these things mattered to me. I wanted my midwives there, guiding me, talking to me, telling me. They knew me so very well, knew exactly what I wanted, what to do, would follow my cues, no silly questions (*do you know if you are having a boy or a girl, are you going to breastfeed?*) in the height of it all.

Did I think about transferring into hospital at any stage – not much. Yes, it was in the back of my head, how could it not be? I had, after all, grown up in the culture of birth being 'normal in retrospect' (Murphy-Lawless 1998) whether I like this or not. I knew I did not want to transfer in because I needed an epidural. I did not want that to happen, I did not want it to be said that I could not 'hack it' (small country, small profession ... small thoughts from me, perhaps, but genuine ones about which I felt strongly). I wanted to *walk-the-walk* considering I had *talked-the-talk* all these years, and have my normal and my natural birth at home with midwives, thank you.

The night arrived and I laboured. I hadn't experienced Braxton Hicks ("practice") contractions during pregnancy so I was fairly sure that something was happening when the cramps came. I did not want anyone to know straight away; I was a primip (first-time mother) and I knew that these pre-labour contractions could go on for a very long time. I could be days like this and annoy everyone (myself included) in the meantime, listening to

me. I slept in-between cramps so, in fairness, they can't have been that awful. The hours passed and eventually I asked my husband to phone my midwives and they started making their way to me. The pool was set up, my mathematically-minded husband had everything laid out exactly as we had discussed. But I didn't want to move out of the bed. All the years of 'suggesting' to women that they should *get up and walk around*, and that *gravity is a great thing* during the early stages of labour no longer seemed important. No amount of suggestions would have moved me from under my duvet. How interesting it is to me now as I write that many of my reflections are written in the voice of a midwife, who has been influenced by the culture of birth, embedded in hospital-based terminologies, practices and observations – Braxton Hicks, time, true labour, early labour.

My midwives arrived and I remember L. climbing onto the bed beside me, hugging me and telling me that I was amazing. I had forgotten that until this writing, but I remember it now and the feeling that "Team Linda" had arrived, let the games commence. There was no need for me to try and get to know new members of the squad as is required of other women who choose a hospital birth in Ireland.

Whilst I tried my hardest to turn off my *midwife brain* it was not always possible. I managed at times to at least have it on pause. I requested VEs,⁸ I think I had three in total – my choice, and interesting to see what routines I held as valuable or important for assessing 'progress' in labour. I clearly remember a need to have a tangible figure to work from, an indication of how far on I was in labour in terms of centimetres dilatation. That surprised me; I thought I had long ago extinguished that part of my midwifery practice. I climbed into my pool and it was pure bliss. The smell of melted cheese on toast wafting around and the music I love playing lowly in the background ... all of this organised by my husband might I add, I didn't need those things don't you know! And I remember a period of fun. Fun in-between discomfort, chatting in-between pains. That went on for most of the day into the evening, it was becoming more challenging, but I could manage. All was fine. Late afternoon I wanted to have another VE, I needed

⁸ Vaginal examination to assess 'progress' of labour (e.g dilatation of the cervix)

more than an abdominal palpation could tell me ... 7cms – yippee. This gave me a pat on the back, the final hurdle. I saw one of my midwives nod at my husband and this gave me a sense of excitement – not long now.

And then it all changed, I began to feel awful. I was thirsty but I couldn't keep water down. Drops of water, an ice pop, licking an ice cube, all induced vomiting and, when there was nothing left to vomit, horrible, horrible dry retching. Sitting in the small, cramped, downstairs toilet not knowing which end of my digestive system was causing me the most discomfort. I was at my most miserable. The blur of hours of misery just passed, I think I was in the pool, I think I was on the toilet, I think I was everywhere and I was content nowhere. But it was ok because it wouldn't be for much longer ... hopefully. The telling on paper can never recall totally the real life time frame but after a period of time the contractions were spacing with longer rest phases and now not as intense, becoming irregular. My midwife brain was in full swing and I was now in desperate mode, because I knew what this meant – a delay in labour that might require the SECM to transfer me to hospital. So we tried EVERYTHING, different positions, attempts at eating and drinking, the dreaded (and I mean dreaded) up-and-down the stairs and lots of other tricks – but no good. No change, no progress, no descent, unsure about the position ... my midwives looking at each other and then looking me in the eye and I knew, I knew what was going to be said, what we possibly had to do. I could read the signs and knew what was considered normal and abnormal within the current scope of midwifery practice, as delineated by the regulations around home birth. S. eased me in slowly *“let's just phone the labour ward, give them a heads-up as to what's going on, see who is there”* So S. did and she talked to them and told us who was there, who was working, who was in charge. Ok, yes, midwives known to me, midwives I liked, it would be fine. And things just happened, there was a short discussion. We – the midwives in the room, knew what we needed to do. S. explained to my husband Steve ... just not moving, progress not as they would like, grab a few bits and let's go I was so sick, so nauseous all I wanted was that feeling to stop. So I went into the back of Steve's old rust bucket of a car and threw myself against S. I felt every bump on the road as we journeyed in, every stone hitting off the

undercarriage of the car and I let this be known – loudly and on several occasions. We arrived outside the hospital and as I got out of the car I was sick all over the footpath at the front door – that was it, I had had enough.

We went straight up to the labour ward, they were waiting and ready for me. ‘THE’ Night Sister was there to bring me into a room, which was a major welcome. I have only a vague memory of the initial time in that room; once I entered I had no idea who was there, what they were doing. I had checked out, I wasn’t there, I didn’t care anymore, I just felt so sick. L. was ‘allowed’ (I chose this word on purpose) to stay with me. I knew the hospital-based midwife who had been assigned to look after me, I had taught her. She was good (my exact thought), she knew what she was at, and yes she could be there! She tried so hard to get me to walk, to get me to breathe during the contractions. She tried so hard to encourage me, to tell me it would be fine. She did everything that I would want her to do, but I did not want to hear, I had done my bit and I had now had enough. I did not want to be there – not specifically the hospital, but there as in anywhere, anywhere in labour. I needed somehow to find me and my space again.

An epidural – that was it, I needed an epidural. If I was to push this baby out I needed an epidural. They were mumbling about syntocinon, I definitely needed an epidural! Poor Steve was so confused “*Linda, you said that was the one thing you did not want*” and the hospital midwife went into support mode “*come on Linda, let’s find a way around this, you’ll be delighted afterwards*”. And I looked at L., just looked at her and L. did what I knew L. would always do if the time came – she took them aside, she explained that if this was what I wanted then this is what I should get. She worked with Steve, showing him that I was making a clear and rational decision and that things change. She bought me some time to try and get some control back, I needed to re-group, I needed to find myself again. I needed a way to stop the pain, stop the sick feeling and refocus back on this labour, focus on whatever it was that first-time mothers in labour are supposed to focus on.

So I got an epidural, I sat up and I let syntocinon infuse and I worked toward pushing this baby out. And that did not really go to plan either. I have been a midwife for long enough, I know L. for long enough ... in spite of all their encouragement, praise and support decisions around doing an instrumental birth were made. It was clinical, how could it not be, I needed it to be? But I was ok; I made sense of my story very quickly and felt like this was something that just had to be done. His head was born and the rest of him did not want to follow, shoulder dystocia, emergency bleeps, people and more people coming into the room. I don't want to focus on his birth here, not because I am not able to - I have, from the moment it happened, been well able to talk about it. But two very amazing midwives and one amazing doctor did what they needed to do and he was born. He required immediate but minimal resuscitation and seven years later he continues to do things his way, in his own timeframe, regardless of what anyone tells him or asks of him! We celebrated, not exactly the Prosecco in the Birthing Pool that I had envisaged, but tea and toast cannot be knocked. Steve was there, L was there, S was there and a little baby boy was there. We hugged, we cried, we took photos and probably made far too much noise!⁹

We stayed in hospital for a few hours. Everyone, I mean everyone, from the midwives to a slightly disgruntled paediatrician did everything they could to help me on my way home. There were boxes they had to tick, hours that were required to pass. Not that there was anything wrong with being in hospital but I felt home was where I should be. We went home and I breastfed and I was sleep-deprived, and my perineum hurt, it hurt a lot, and it was all just very wonderful and exhausting. People came to visit, they phoned, they emailed and they asked A LOT of questions.

“Your homebirth, what happened? Was it awful? Were you gutted? Transferred, how awful for you. Were you disappointed? Were you tempted not to go in? How did they [hospital staff] treat you? Were they mean to you? What did they say when you went in? Bet they were “thrilled” to see you coming in? Did they mock you ‘cause you

⁹ Labour wards in Ireland tend to be the ‘quietest’ I have experienced. This could be construed as a sign of the Irish mentality of not making a fuss or perhaps it is a reflection of the number of women who avail of an epidural during labour?

didn't have your home birth? Did they do everything you wanted to avoid? Would you try for a home birth again?"

All the questions, some did not make sense to me. Was I disappointed – well I had planned a home birth with my husband and my midwives for specific reasons. I didn't birth my baby at home, but I had everything else in relation to home birth that I wanted- my husband there, my two midwives there, a vaginal birth (albeit an instrumental one). So, disappointed?– too strong an emotion; gutted? – definitely not. The sense I made of my story by reflecting on it, and discussing it with my husband and friends, helped me to come to terms with any disappointment I might have felt. My labour played out the way it did; decisions were made that were appropriate for that moment in time and space. Above all, I never felt ignored, not listened to, not cared for. I never felt frustrated or disappointed with the care I received - the opposite, in fact. Yes, I had interventions and made certain choices, but the sense I made of it was they were for good reasons; they were not based on routine, and I had control. *Was it awful / were they awful?* - far from it, why would they be? *Did they mock me ... were they mean to me?* – WHAT???? What did these questions mean? Were the cultural beliefs in relation to birth so disparate that taunting was a possibility? In some people's view (other midwives who worked in tertiary hospitals), apparently, yes, the divide between hospital and home is so great that they truly believed I might have been taunted for my lack of home birth.

What was going on, why all the questions, why those type of questions, what was I missing? Was I treated differently because I am a midwife, because I am known to the hospital-based staff, because I know *the system*? Did I act differently because I am a midwife, because I am known to the hospital-based staff, because I needed to conform to *the system*? So months and months after the haze of maternity leave began to diminish I did what I generally do – I talked to people. People I consider to know what they are talking about (my midwives, my colleagues, other women). Not all my questions were answered and in fact I now had a lot of new ones. So that

was it – I thought about all these questions for a while, and had another baby¹⁰ (in October 2009). But the questions remained-

What happens when women who plan to have a home birth transfer to hospital during their labour? Home to hospital, home birth to hospital birth, midwife-led to obstetric-led, normal physiological birth to medicalised birth- what are the effects of changing from one model of care to another?

2.3 Where it all Began – My Professional Story

My personal birth story has an important influence on the focus of this study, but my professional experiences and beliefs must also be explored at the start of this ethnography in order to acknowledge the impact that they have in shaping and influencing my thinking and my cultural beliefs in relation to birth.

I tell anyone who asks ‘what do you do?’ *I am a midwife! I am a midwife* - even during the periods of my life when I wasn’t face-to-face with pregnant women. During those times when I enthused (tried to) and challenged and perhaps went on-and-on a bit about women, pregnancy, birth, breastfeeding, midwifery as I paced around the lecture theatre in front of unsuspecting midwifery students! The vast majority of my experience as a midwife has been in a hospital setting. I have, however, worked within models of midwife-led care and in community-based midwifery practices (urban and remote, in Ireland, England and Australia). The differing cultures experienced in the different countries are explored later in this section.

I am not sure how, or when, exactly I made the choice to become a midwife. I was a nurse (for a brief period) prior to my midwifery education. Birth – I knew little of it, I did not grow up surrounded by it. I do not come from a Big Irish Family; I have one sister. I knew that ‘*I was a forceps delivery*’, born in a *nursing home*, my mother ‘attended’ by the family GP. I have a memory of her saying “*they told me to stop making noise, told me I was*

¹⁰ In case either of my children ever read this work (a mother can hope) and think one birth had more impact than the other - my 2nd son was born via an emergency caesarean section following the prolapse of his cord whilst I was an ‘in-patient’ on an antenatal ward. He came out of my belly screaming. After his birth several of my midwifery students asked me not teach them the ‘emergency drills’ any more ... or at least wait until I had finished having my own babies! Drama, excitement and trouble epitomise this boy!

frightening the other women". Now I am unsure if this memory is from my growing up years or if it was recalled during my time as a midwifery student, a time when she told me "*never be one of those cruel midwives*". It is also interesting that some of my thoughts in relation to the birth of my first son focus on the noise we were making, and that I thought that we were too loud for the environment of a labour ward!

I 'met' midwifery for the first time during a one-week allocation to the maternity unit in the 2nd year of my three-year 'nurse training'. I remember, I can picture the other nursing student beside me, hearing, for the first time, a fetal heart, the day I saw birth for the first time,... and I wanted in, I wanted to be part of this amazing, this special, this magical time. I wanted to be part of that clique, the bond that I witnessed between the midwife and the woman. Once I made that decision, there was no going back.

And suddenly when you say you are going to be a midwife - pregnant women, women with babies, women planning to have babies are everywhere and they want to talk to you. Cousins in the UK started having families, having home births, breastfeeding babies. Coming home to Ireland with slide shows of home births, birthing pools, breastfeeding, I had never experienced this before. I had experienced women giving birth in hospital, lying on a bed attached to a monitor, the majority of them formula feeding their newborns, but it was fascinating. And I wanted to see more. I decided to go to London and 'do midwifery' there, be exposed to all the community midwifery I would not see in Ireland (a tutor had just returned from 2 years working at Queen Charlotte's in London; she spent her days regaling us with stories of 'the district', reinforcing the stories my cousins told). We (my fellow student nurses and I) heard that midwives were more autonomous over there; there was talk about "The 3 - C's of Choice, Continuity and Control"; I was not sure what that meant but it sounded promising and combining that with community midwifery was just too enticing to miss. I don't really know why I felt such an attraction to something that I had no exposure to, but it just felt right. At this time I did not question why choices in relation to models of maternity care were not as readily available to women in Ireland (at that point I did not even know if

women in Ireland ‘were able’ to have home births); I accepted the organisation of the maternity services as just the way things were.

I became a midwife, and after registration I worked in London and in Australia. The 3 C’s of the Changing Childbirth Report (Department of Health, UK 1993) offered an opportunity to protect and develop options of maternity care for all women. In 1995 this philosophy and the culture of change it brought with it made choice in relation to models of maternity care seem, to me, to be perfectly normal. Australia is where I believe that I truly became a midwife. A period of time working in the outback of Queensland facilitated the development of my confidence in myself as a midwife. On reflection, this was the first time I experienced birth in hospital that wasn’t, as a norm, ‘managed’; no pressure to empty the labour ward because of a queue of women in labour waiting. I suddenly was aware of time, by that I mean spending it with women, endless amounts of time focused around their needs, planning around their needs. While I felt that I had so much to learn during my experience in the outback I was surprised that the practitioners in the urban hospitals felt they could learn from me. I represented something progressive. I was young and enthusiastic, I was fresh out of a busy labour ward in London, I had an honours degree and midwives in Australia couldn’t get enough of “what would *ye* do Linda?” Obstetricians assumed that my thick Irish accent equated to vast experiences (and staunch support) of Active Management of Labour thus leading to some lengthy conversations and debates around the issue.¹¹

I came back to work in Ireland in the summer of 1999 and the return was challenging. Maternity care was much more obstetric-led than I had realised it would be and totally hospital-based. Even in writing this I wonder how I was so surprised, as I had been exposed to this prior to my overseas experiences, but my reference points had now changed. When I had last

¹¹ Active Management of Labour originated in the National Maternity Hospital (NMH), Dublin in 1963 and has been widely adopted in maternity care in Ireland and exported across the globe as a means of obstetrically managing women’s labour (Murphy-Lawless 1998). The National Maternity Hospital continues to facilitate “Active Management of Labour Courses” educating new generations of midwives and doctors in the components of medicalised birth. Participants come from Europe, America and as far away as Australia to attend these courses (personal communication, NMH October 2013). <http://www.nmh.ie/education/active-management-of-labour-course-2014.1841.html>.

experienced the maternity services in Ireland I had done so as a student nurse in the early 1990s, a time when nursing in Ireland was completely subservient to the medical profession. The profession of nursing was also organised within a very hierarchical structure and student nurses were on the lowest rung of the ladder (it appeared that midwifery here was organised in a similar manner). Exposure to other models of maternity care, the role the midwife held in other countries and inter-professional relationships with the medical profession I had experienced abroad led me to question what was considered normal and acceptable within the culture of the healthcare service in Ireland. Care was based around tasks, midwives did the bidding of doctors and the mantra of "*this is the x hospital way of doing things*" was heard frequently.

In 2001 I moved into a teaching role where I felt, at the time, I could best facilitate and support the development of midwifery practice. And I was right in that I found I had a voice, or rather, this role lent itself toward my using my voice. Midwives saw me interact with the midwifery students, as I was teaching not only in a classroom but also out in the hospital, highlighting that I had not forgotten where I came from. My opinion and support were sought; the midwives invited me onto hospital-based committees; I talked of evidence-based, women-centred, midwifery care, and I continually promoted options and choices. But my audience consisted of midwives and women who had already entered the maternity care system. Midwifery education moved into the universities in 2006 and I moved with it, becoming a lecturer in midwifery under a national agreement. To the lecture theatre, where I espoused about birth and midwifery, waxed lyrical some might say, and hoped that the difference I so wanted to make was still within my reach even if I was now physically more removed from the sites of maternity services than ever before.

The relocation of midwifery education and my transfer to the university placed another emphasis on my professional development and the supports I could offer to midwifery and to women accessing the maternity care system. In addition to my role as a practitioner and an educator, I now had a research remit. I was committed to conducting research that would make a

difference and participated in several local studies, which had an impact on small areas of midwifery care and midwifery education. I kept coming back to choices and options for women and to those (big) unanswered questions that emerged after the birth of my first son. The questions that I wanted to ask, the answers that I needed to make sense of the worlds of women who choose homebirth, of the worlds of those offering maternity care (at home or in hospital) and of the space they co-inhabit. As they were questions no one else was asking, I enrolled on the PhD register at Trinity College Dublin (October 2010) and this study formally began.

2.4 My Questions About Birth in Ireland

The questions I ask relate to the understanding of birth, what influences the understanding and in turn how does this influence the organisation of maternity care and women's lives? Using ethnography to explore, firstly, my own birth stories and professional development and, secondly, my readings on birth and birthing internationally and, more specifically, in Ireland helps me to make sense of some of the background issues exploring culturally-embedded beliefs.

There seemed (to me) to be a curiosity in relation to my story and experience of birth -

How I was received on transfer? What did the hospital-based staff think of it all? How did they / we interact? How did this impact on my birth experience? Was it awful?

I began to wonder if my *insider* status had blinded me to the issues that some of these questions raise or if they were not issues for me simply because of my *insider* standing? My personal story is just that – personal; however, it remains impossible to divorce the professional part of my thinking when reflecting on my experiences and I question the influence who I am (professionally) had on my story and the sense I made, and continue to make, of it. I acknowledge freely that I was in a 'unique position' during my antenatal period (Biesty 2012); did this mean that my in-labour transfer was somehow unique as well? From the onset of my pregnancy I navigated a model of care that was not available to other women; I negotiated this model drawing in what I believed to be important

during pregnancy and childbirth (support, empowerment, consultation, trust). I achieved this by engaging with other health care professionals as an *insider*. I know the cultural beliefs in relation to birth and how this impacts on the way birth is organised and managed; I know the language, I understand the workings and idiosyncrasies of the system and the peoples. For example, I know that labour that does not “progress” according to an agreed rate is deemed to be “delayed”, or “slow” or “abnormal”. In particular, I know that when contractions cease near the end of the first stage of labour, it can denote a problem. Did my *insider* knowledge impact on how I interacted with other health care professionals during my transfer and, equally, on how they interacted with me? I began to consider the experiences of other women, women who are not known to the hospital-based staff and perhaps have little or no knowledge of the culture of birth in a hospital. I propose that I “needed” to be transferred to hospital; other women’s understanding might have led them to view their transfer (if for the same reasons) through a very different lens. Jomeen (2010) suggests that hearing women’s stories across their experiences is necessary to identify the meaning within their experiences. I was interested in hearing the women’s stories of transfer and exploring the contribution they could make to the discourse surrounding birth and home birth in Ireland. I wanted to find out what was central to the culture of homebirth in Ireland that is not central in the culture of hospital birth using a technocratic model, although perhaps it should be.

2.4.1 How to Make Sense of These Questions

This study arose from a desire to explore women’s experiences of in-labour transfer to hospital during planned home birth, stemming from curious reactions to my birth story which, at the time, did not make sense to my personal experience of the interface of home and hospital birth. The aim of the study emerged from an aspiration to understand, to change (if necessary), to provide robust evidence to inform the organisation of the maternity services and to make a difference to women’s lives. As previously noted, the models of maternity care provided for women in Ireland are “*lagging behind*” when compared to those available in Britain and elsewhere in Europe (Begley et al 2009, p.16). Choice is limited and options

outside the dominant obstetric-led, hospital-based provision of maternity care are not well developed (I will explore this in greater detail in Chapter 4). Seeking a home birth is, for the most part, regarded as stepping outside the conventional model of care. I have witnessed the polarisation of views within the maternity services (in Ireland and other jurisdictions) and the two ideologies which exist. One sees birth only as normal in retrospect and therefore needs significant technological surveillance and intervention (Lane 2012); the other views birth as a normal physiological process that is undermined by the routines of institutional interference (Reiger 2006). I understand the impact that the former view has on the organisation of maternity care in Ireland and the dominant place it holds in the provision of the maternity services. My interest lay in exploring the experiences when these two ideologies / these two cultures converge at the intense time of in-labour transfer to hospital during planned home birth.

Turing to the empirical literature offered me little insight to the questions I asked. The subject of in-labour transfer has received limited attention and for the most part focuses on the rates of and reasons for transfer (Johnson & Daviss 2005, Amelink-Verburg et al 2008, Lindgren et al 2008a). No qualitative data focusing specifically on women and their experiences of transfer existed.¹² The scant quantitative studies that have been conducted offer contradicting results. Data from the Netherlands (Wiegers et al 1998) have shown that when community services are integrated with hospital services the processes around in-labour have no influence on women's birth experiences or their evaluation of their birth. Wiegers et al (1998) suggested that transfer to hospital during planned home birth has little influence on the birth experiences of women in the Netherlands. This study, conducted between 1990 and 1992 extrapolated data from questionnaires (n=2301, response rate 89.3%) sent to pregnant women 4 weeks before their baby's

¹² The work of Creasy (1997) has been cited elsewhere (Fox et al 2014, see Chapter 9) as a reference for women's experiences of in-labour transfer to hospital. This qualitative study explored women's experiences of transferring from community-based to obstetric-based services. Twelve women, who opted for "community booking", participated in this study. Four of these women transferred to obstetric care during pregnancy. The other eight women transferred to obstetric care during or immediately after labour. Only two of these women had planned a home birth and it is impossible to isolate their data from that of the other women who planned to birth with a named midwife in a "community room" in the maternity unit.

birth and at 3 weeks after the birth. Four hundred and thirty four nulliparas and 623 multiparas women planned to birth at home. A transfer-to-hospital rate of 39.3% (nulliparas) and 10.3% (multiparas) was recorded. In the postnatal questionnaires women were asked if their expectations had been met (in relation to their evaluation of the birth, the care from the midwife and the postnatal period). A five-point Likert scale identified that no significant difference was noted in their experiences. In contrast, women in Christiaens et al (2007) and Lindgren et al's (2011) studies highlighted their dissatisfaction with experiences of in-labour transfer. Christiaens et al (2007) found that women in the Netherlands and Belgium, who planned a home birth and transferred to hospital, were less satisfied with childbirth when compared to women who planned and birthed in hospital. Women in "a comparable" city in both of the countries were asked by their primary care giver to participate in the study and complete two questionnaires¹³. While the Netherlands has an integrated maternity system this is not reflected in the model of care in Belgium. At the time of the study home birth care in Belgium was offered by an independent midwife who did not remain with the women after transfer. Due to the recruitment strategy the researchers were not aware of the response rate, postnatal questionnaires were filled in by 605 women (Belgian women = 261, Dutch women = 344). Thirty seven percent of the sample had planned to birth at home (Belgian women = 24%, Dutch women = 48%). The referral to hospital rate was 7.1% for women in Belgium and 29.6% for women in the Netherlands¹⁴. The main findings of the study suggested that women who planned a home birth but birthed in hospital were less satisfied with their overall birthing experiences than those who intended to and birthed in hospital. Similar findings were reported in a study conducted in Sweden. Lindgren et al (2011) explored the birth experiences of women who planned a home birth between 1998 and 2005 and compared the satisfaction of those who birthed at home with those who transferred to hospital during / immediately after labour. Less than 1% of Swedish women birth at home (Lindgren et al 2008b), it is not recommended by the department of health and is not an

¹³ The women were asked to do this at 30 weeks gestation and two weeks after childbirth.

¹⁴ A breakdown of the number of multiparous and primiparous women is not offered

option within the public healthcare system (Lindgren et al 2008b).¹⁵ Six hundred and seventy one of the 674 women who had planned a home birth completed the study-specific questionnaire (which included one open ended question in relation to transfer). Ninety-five of the women experienced a transfer to hospital during labour or after the birth of their baby, 81 responded to the question on transfer. Women who transferred to hospital and those who had a planned home birth were compared in relation to their satisfaction with care during their pregnancy and birth. Overall satisfaction with experiences was shown to be higher in the group of women who birthed at home (82.8%) compared to women who transferred to hospital (26.3%). Women who transferred to hospital were less satisfied in relation to the medical and emotional aspects of birth (37.4% versus 71% and 29.5% versus 80.4% respectively), and also their ability to participate in the decision-making process once transfer to hospital occurred (43.2% versus 85.2%). The open ended question yielded qualitative data in relation to “treatment” (negative attitudes of hospital staff), “organisational factors” (home birth midwife not allowed to stay) and “personal ability” (feelings of not having achieved their planned home birth)” (Lindgren et al 2011, p103). Whilst the value of these works is acknowledged, the studies offer some insight into women’s satisfaction and dissatisfaction when women do not fulfil their plans to birth at home. However, a more complete understanding than can be accessed using quantitative methods alone is needed. It must be noted that these do not provide an in-depth exploration of “dissatisfaction” or the contribution factors. These studies do not account for the specific issues within the organisation of maternity care and the culture of birth in Ireland.

My readings of ethnography (see Chapter 5) and how it would help me to make sense of my questions led me to the aim of this study - to explore and understand the culture of birth in Ireland at the interface between home and hospital, as experienced during in-labour transfer to hospital during planned home birth, from the viewpoint of all key stakeholders.

¹⁵ Approximately 25 home birth midwives are reported to exist in Sweden many of them are also employed in the delivery suites of the country’s maternity hospitals (Lindgren et al 2008b).

My initial plans only involved the participation of one group of the key actors – the women who experienced in-labour transfer. However, during the preparatory stages of this study it became apparent if I was to explore the interface between home and hospital as experienced at in-labour transfer then it was imperative that all those centrally¹⁶ involved during the time of transfer informed this work. ^{Diary Entry 1} The absence of published research in relation to women and their healthcare professional's experiences of in-labour transfer must be acknowledged and draws attention to the uniqueness of this study.

Whilst not specifically studying unplanned transfer to hospital, Davis-Floyd's writings emerge from her anthropological research and writings (spanning over 20 years) exploring the process of professionalisation as experienced by direct-entry¹⁷ midwives in the US and to a lesser extent in Mexico (Davis-Floyd 2003). In-labour transfer (transport) to hospital when home birth was planned has been raised as an issue for midwives participating in Davis-Floyd's studies. Their narratives highlight experiences, which range from positive and supportive for all involved to antagonistic and confrontational. Coining the interactions as "articulations", Davis-Floyd (2003, p. 1912) proposes that the experiences of transfer to hospital can be divided into 3 main categories –

Disarticulations

Fractured Articulations

Smooth Articulations

depending on the level of mutual respect, communication and support that characterises the interactions of the direct-entry midwives and hospital staff during the transfer process. In 2003 Davis-Floyd charged future ethnographers to conduct comprehensive explorations of in-labour transfer to include women and healthcare practitioners. I undertook that task.

¹⁶ Women, SECMs, HMWs and obstetricians

¹⁷ Home birth (or sometimes Direct Entry) midwives are not nurses and in the USA have several options of education included accredited and non-accredited schools, apprenticeships with home birth midwives or apprenticeship at birth centres. The status (legal) and registration of these midwives varies across the states.

So I went out, I went out into the research field(s), to women's homes, to midwives' homes, to hospitals, to doctor's offices, to playgrounds, to beaches, all hours of the day and the night – to wherever the participants and the data took me. I watched, I listened and I asked questions. I buried myself in all things homebirth and in the space where home and hospital birth met. I explored, I uncovered and I learned. Undertaking an ethnographic study with extended periods of fieldwork facilitated my immersion in the culture of homebirth in Ireland. I observed the decision-making, communication and interactions of those at the center of an in-labour transfer; I observed joy, elation, pain, disappointment and fear. I explored the culturally embedded interface between home and hospital birth. The remainder of this thesis charts that journey, where it led me and my navigations *en route*.

2.5 Summary

This chapter has outlined the problem existing in Ireland, where there is a dichotomy between the philosophies and cultures of home and hospital birth. There is a need to hear, first-hand, the stories of women who have had to transfer, in labour, from a planned home birth to a hospital situation, and to explore the views of other key participants at that time. An outline of the limited research in this area has been presented, with the critical gap in knowledge highlighted. This ethnographic study, with extensive immersion in the field of home birth, will contribute to the discussion on models of maternity care and how transfer is negotiated within a cultural milieu that aspires to offering women choice. The timing, scope and significance of this study are unique. This thesis will contribute to knowledge in an effort to best improve the maternity services for all involved.

I move now to Chapter 3 and 4, these chapters detail the background literature read and analysed to provide a framework for the context of birth in Ireland.

(For Fieldnotes and Diary Entries please see Appendix 2, Pages 425 – 426)

Chapter Three: Framing the Context of Birth

3.1 Introduction

Birth is a cultural event and is located within a multitude of discourses, which cross medical, historical, political and sociocultural boundaries (Jordan 1993). The last three hundred years have seen a profound change in the social meanings and cultural interpretation of birth in the Western world (Lowis & McCaffery 2004). These changes in the way childbirth is viewed occurred primarily in Europe but spread to North America, Canada, New Zealand and Australia via colonialism and capitalism (McCourt and Dykes 2009). Reference in the histories of birth and the organisation of maternity care in Western countries is made to the influence of gender, professionalisation and professional boundaries, and the medicalisation of birth on these happenings (Arney 1982, Donnison 1988, Garcia et al 1990). From the 1700s pregnancy became increasingly viewed as a situation that could result in high death rates for mothers and infants, (Donnison 1988) requiring medical intervention and surveillance; this was further influenced by the juxtaposition of risk and safety associated with modernity (Lupton 1999). Maternal mortality rates at that time were 10.5 per 1,000 live births (Chamberlain 2006). The late 19th and the 20th century saw birth moved, for the most part, from home to hospital, from a domestic to a public context and with this the role of the midwife was reduced in some countries to that of an 'obstetric nurse' (Murphy-Lawless 1998), while in other countries, (namely North America and Canada) midwifery was outlawed completely (Davis-Floyd 2006). As women's choices in relation to carer and to place of birth became increasingly limited, the growing reliance on doctors to manage birth with technology was further reinforced (vanTeijlingen et al 2004). Oakley (1993) suggests that this '*medicalisation of childbirth*' had the effect of almost totally transforming cultural understandings of birth in the Western world.

This chapter is divided into two parts; the first explores the cultural and historical shifts in the understanding of birth, drawing predominantly from historiographies of birth from the UK but also drawing on work from North America and Australia. This was considered appropriate given that the

traditions and governance structures of the UK, up until the formation of the Republic of Ireland in 1922, are significant to birth in Ireland. As the consideration of historical context is necessary if a deeper understanding of contemporary issues is to be found (Edwards 2005), the second part of this chapter explores the culture of birth in Ireland and so situates birth in the twenty-first century.

This review aims to reveal the issues that are relevant to this study by illuminating the cultural transitions that influence the current provision of maternity services. Central to this exploration are the health care providers who are situated historically in competing discourses, which have influenced how pregnancy and birth are socially constructed and culturally embedded. The voices of women are also important but are often lost to history, as they were less well able (and often prevented from) leaving written evidence of their beliefs and experiences around birth (McIntosh 2012). I acknowledge the influence that patriarchy has had on the development of professions and the organisation of the maternity services, but I am also cognisant of the over simplistic view that all doctors [male] are *bad*, all midwives [female] are *good* and all women are oppressed. While it is difficult to avoid a dichotomous reading of the discourses of birth and place of birth, I am mindful of postmodern feminist thinking that challenges these stereotypes and lends itself to the possibility of exploring less totalising discourses of childbirth (Annandale and Clarke 1996).

3.2 Birth in the Western World from the 16th Century to the Present Day

3.2.1 The Traditional / Lay Midwife

Birth as a medical event is a social construction of the last 300 years restricted for the most part to Western society (Kitzinger 2000). Prior to the Enlightenment in the late 17th century, birth was located in the domestic sphere; women were supported by other women (McIntosh 2012). Pregnancy and birth were viewed as being *women's business* and existed within a private, female realm with midwifery embedded and intertwined within the community (Oakley 1984). Murphy-Lawless (1998) highlights

that the knowledge that women drew from during birth, and the meaning it held within society, was drawn from women's embodied experiences.

The manner in which midwives worked varied; McCourt and Dykes (2009) suggest that this was most likely influenced by the needs of their community. Leap and Hunter (1993) and Turner (1995) make the distinction between two different types of *midwives* -

- 1) women who had been apprentices to older midwives and worked in a formal capacity as the midwife within a specific community. New midwives thus learnt by following older, experienced ones;
- 2) local women who were known within their community as *women who helped during birth*. These women practised in an informal way, often supporting family members or neighbours of little means who could not afford the services of the more formal midwife noted above.

These women came from across the social spectrum with diverse experiences and levels of competence (Marland 1993). Midwifery skills and knowledge learned in this apprenticeship manner was not regulated in the manner that we have become accustomed to today in Ireland, nor was licensing required. This changed over different timeframes in different parts of Europe with varying consequences in relation to the survival of the traditional role of the midwife (Donnison 1988).

Although considered a normal life event, birth was also a secluded event surrounded by female, mystery, rituals and taboos (Ehrenreich & English 1973). As women had no access to 'formal' education it was often assumed that the skills of a midwife came from supernatural sources (Evenden 2000). The late Middle Ages saw the craft of midwifery aligned with superstition and as a result midwives came under persecution (Donnison 1988). The powerful Christian Church (primarily the Catholic Church and also in the latter years of the 16th century the Protestant Church) instigated this persecution, based on a belief that the skills of midwifery were *powers* derived from the devil and therefore could be used to inflict harm on others (Ehrenreich and English 1973). The helping and healing properties used by the midwife were also viewed with suspicion and included in the 'crime' of witchcraft (Ehrenreich & English, 1973). The stories of female healers and midwives are intertwined within the writings of the middle ages; however,

both were tortured and, at times, condemned to death by the Church (Minkowski 1992). The late medieval period saw ‘physicians’ attend to members of the noble classes. The physician was not only a male but also a member of the ecclesial community (usually a priest); he was under the control of the Church and therefore exempt from persecution and considered acceptable (Wilson 1995).

Aside from a preoccupation with witchcraft, the Christian Church was concerned with midwives for another reason – the rite of baptism (Elmer 2004). Midwives were deemed to be best placed to ensure that newborn babies were baptised into the *one true* faith and therefore of major importance to the Church in the religious conflict and divisions of the late 16th century (Elmer 2004). The midwife was also in a position to report cases of illegitimacy and infanticide; this was a role encouraged by the Church so as to obtain information relevant to the ‘morals’ of their congregation (Wilson 1995). In order to gain an authority over birth, or more specifically over midwives, the Christian Churches of Europe instigated the licensing of midwives (McCourt and Dykes 2009). Historians have difficulty in identifying the exact date when the Church first issued midwifery licenses; however, some evidence exists to demonstrate licensing by the Archbishop of Canterbury in 1567 (Donnison 1988). While ecclesiastical concerns were the main focus of the Church’s licensing, Harley (1990) notes that fears were also raised in relation to the competence of midwives and the safety of their practices. Whether this was justified or not is difficult to critique as the skills of midwives were intertwined with claims of witchcraft, so differentiating between concerns in relation to competence or those of superstition is difficult (McIntosh 2012). In addition, the lack of education of women at the time meant that midwives were usually illiterate, so the narrative of the care they provided is not recorded. The persecution of ‘sinful’ women who did not conform to licensing is recorded; this eliminated an unknown number of midwives and, with them, destroyed a whole history of midwifery and women’s health (Murphy-Lawless 1998).

In order to secure a license in England, a member of the religious community had to vouch for the good character of the midwife and she, in turn, had to take an oath with 10 concerns (e.g. not to conduct witchcraft, not to conduct an abortion, not to baptise the newborn into the incorrect faith, to maintain confidentiality) (Evenden 2000). The Oath stipulated that the 'secrets of the birthing chamber' were to be kept from men, and that men were only admitted in the case of an emergency (Evenden 2000, p. 28). While The Church of the late Middle Ages viewed the female midwife as the appropriate presence at birth, this was within the context of caveats designed to meet their ends. This licensing is one of the first examples of a body (or profession if you will) outside of midwifery defining and controlling the role of the midwife for their own end.

3.2.2 The Emergence of the Man-Midwife

The 17th century saw an increase in men's participation in birth as '*man-midwives*¹⁸', the forerunners of obstetricians (Donnison 1988). The acceptance of men into the women's world of childbirth did not happen overnight, yet by the 19th century men had well established themselves as the attendant at childbirth for women of wealth and those of extreme poverty in the urban areas of Britain; this trend spread across most of the countries of the Western world (Dahl 2001). The man-midwife was placed in direct competition with the traditional female midwife. During this time the philosophy of birth changed from a *woman's mystery* to *man's science*. It is difficult to surmise if this facilitated the rise of the man-midwife or if this change was driven by the man-midwives themselves; Ehrenreich and English (1973) suggest a combination of both factors was at play.

Up until the 1700s men's involvement in birth was limited to that of barber surgeons (the Guild System of the 13th century in the UK granted these surgeons the right to use a surgical instrument). They were called by the midwife to 'extract' the baby when birth was deemed to be impossible, in an attempt to at least save the woman's life (using, for example, a

¹⁸ In this chapter the term *man-midwife* is used for the male practitioner until the 20th century and *obstetrician* thereafter. The Royal College of Obstetricians & Gynaecologists (RCOG) was formed in 1929.

craniotomy hook) (Simonds et al 2007). Ehrenreich and English (1973) suggest that midwives sought the involvement of barber surgeons in childbirth, not necessarily because of a belief in their expertise, but because they (women, midwives) were not permitted to use the necessary instruments or to 'decapitate' dead babies for extraction. The decision to involve the surgeon was made by the midwife often after she had instigated practices that were unsuccessful in alleviating the obstructed labour (Simonds et al 2007). Their initial foray into the afore-mentioned *birthing chamber* saw man-midwives encounter resistance from women and from midwives (Donnison 1988). Women feared the involvement of men, as their presence and instruments were associated with the difficult birth of a baby, a baby that was already dead (Marland 1993). Women's concerns in relation to propriety were also recorded and the potential of physical contact between men and women during labour was viewed as controversial (Porter & Wear 1987). From the midwives' point of view Jane Sharp¹⁹ noted that traditional female midwives questioned the need for man-midwives, holding the view that they (the midwives) would more than suffice at birth where, after all, the workings of nature were at play (Chalk 2009). This demonstrates an early reference to the different ideologies in relation to the understanding of birth. To overcome the cultural view that only women could be [or needed to be] present at birth the man-midwives had to legitimatise their role, and used the emerging scientific influence of the Enlightenment period to further this cause (Chalk 2009). The dualistic thinking, which separated the mind and body, predated the Enlightenment period; however, Cartesian dualism and its preferencing of the rational mind over the body reinforced the superiority of intellect (Brooks and Lomax 2000). This gave man-midwives an ideology that valued their 'new' scientific knowledge (Murphy-Lawless 1998).

The development of the forceps in the 1700s is described as a defining moment for the man-midwives. Not only was the instrument credited with saving lives (Shelton 2012), but it also enabled male attendants to establish themselves as central to the process (Arney 1982). Female midwives were

¹⁹ Jane Sharp was an English midwife from the 17th century, the first woman to publish a book about midwifery (*The midwives book: or The whole art of midwifery discovered*)

not permitted to use forceps (Marland and Rafferty 1997) as “*an instrument of that sort clearly called for more knowledge and skill in its use than could be expected of a midwife*” (Johnstone 1952, p. 30). At an early stage, the development of the instrument and the man-midwives’ skill in its use were more akin to torture, as decapitated babies and physical harm to women are recorded (Shelton 2012). In spite of this, this procedure was held (by man-midwives) to be one that transformed the safety of birth (Donnison 1988), an opinion that was given longevity by the writings of William Smellie and William Hunter (man-midwives deemed to be the *Founding Fathers* of the obstetric profession) (Shelton 2012). Wilson (1995) identifies this as an important point in the time line of midwifery and obstetric science and heralds it as the beginning of the transformation of the man-midwife to be first the cultivated specialist and later to become today’s obstetric doctor. The forceps enabled male birth attendants to establish their role in the management of abnormal births and make claims in relation to their newfound skill and expertise in saving women’s lives (McIntosh 2012). Successful outcomes associated with the use of forceps began the dissolution of the association of male-midwives with dead babies; this separation was vital for their future acceptance by pregnant women during birth (Marland and Rafferty 1997).

While the impact of the man-midwives’ involvement in operative midwifery preceded the move of birth to hospital (Mander 2004, McCourt and Dykes 2009) propose that the increase in maternity ‘*lying-in*’ hospitals (of 18th century Europe) had a major influence on the advancement of the man-midwife and changes in the cultural understanding of birth. Charitable lying-in hospitals (the first one in Ireland – The Rotunda, Dublin was established in 1745) offered services to the poor women of urban areas (Browne 1995). The growth of these hospitals served to support the man-midwife and the developing medical specialty of obstetrics in two significant ways –

- 1) they provided a venue, and a ready supply of anatomical specimens, for the formal training and teaching of students.

2) they placed the women of lower class under the supervision and control of man-midwives.

(Schiebinger 2000, p. 26).

The former facilitated practical learning using real women, and dead women and infants, to advance techniques and knowledge (perfecting their role during obstructed/abnormal birth), whilst the latter saw man-midwives establish a presence during normal birth (Murphy-Lawless 1998). Locating birth within a hospital setting gave man-midwives the practical experience of normal birth denied to them by midwives and women alike in the community. Drawing from the role of surgeon and the female midwife, lying-in hospitals enabled the man-midwife to develop a new tradition, which completely altered the culture of birth and the environment in which birth occurred (Marland and Rafferty 1997).

The 18th century saw also the reorganisation of medicine to incorporate university educated physicians as well as the apprentice trained surgeons (Willis 2006) thus extending the body of knowledge (and practice) within the 'learned profession' of medicine (Turner and Hodge 1970). 'Professions' of this era were held in esteem and distinguished the occupations of rich, middle class men from trades, which were considered socially inferior (Friedson 1986). The university education and the supremacy associated with academia (Lindemann 2010) gave the emerging profession of obstetrics an authority that was to lend itself to obstetric science establishing its dominance over the knowledge of childbirth (Murphy-Lawless 1991,). In contrast, midwifery was viewed as a craft, and was learnt through an apprenticeship system of oral tradition and extensive practical experience (Oakley 1984). Although midwifery texts were available, their impact on practice is not clear. Conflicting reports exist in relation to the social status of the midwives, some suggesting that they were from the lower classes and therefore illiterate (Gelis 1991). Other accounts hold them as literate women from middle class backgrounds (Kalisch et al 2004), a change that may have occurred in tandem with increasing regulation and certification. It is more likely that midwives of the 18th century came from both social classes; however, regardless of their literacy

status, women were excluded from obstetric education and training until the middle of the 19th century and had no access to any formal instruction in physiology (Arney 1982). With the development of their formal training and education, man-midwives aligned themselves to so-called detailed, objective, professional learning and expertise, an alliance traditional midwives were not in a position to make (Sommers 2011). Decreasing maternal mortality rates, at 5 per 1,000 live births in the 19th century (Chamberlain 2006), may have been claimed by man-midwives as due to their expertise.

While man-midwives advanced their role in birth, traditional midwives continued to support the women of rural areas; the lying-in hospitals catered for the poor and destitute of urban areas, whereas women of means could engage the services of an accoucheur, often alongside a midwife. These midwives saw the male practitioners dismiss their efforts as ignorant and non-scientific (Murphy-Lawless 1998). The authority of the midwife was also undermined by popular culture; exemplified by characters such as Sarah Gamp a dirty, gin-drinking, *midwife, nurse and layer-out of the dead* character of Charles Dickens's novel 'Martin Chuzzlewit' (Summers 1989). The claims to legitimacy of the man-midwives are demonstrated clearly in the midwifery texts (written by men) of the 18th century (McIntosh 2012). While the writing of the 17th century explored the knowledge of midwives and their remedies, the obstetric texts of the 18th century had a clear change in theme and subject matter (Dahl 2001). The limitations of the traditional midwives are clearly documented; their knowledge was no longer considered sufficient. Oakley (1993) goes as far as to describe the texts of the 18th century onwards as 'anti-midwife'. "Untrained, ignorant and dirty midwives" (Dahl 2001) were seen as a danger to society (McIntosh 2012). Poor women could not afford the fee of 'skilled' professionals and so continued to engage cheap birth attendants, often untrained neighbours. Tew (1995) suggests that this led to an association between midwives and poor outcomes, an association that was exploited by obstetricians into the 20th century. Man-midwives promoted the more technical aspects of 'difficult' births, placing emphasis on the knowledge and experience needed to use forceps and other instruments (Shelton 2012). Great weight was

given to the knowledge of anatomy and the man-midwives' ability to acquire the formal learning needed to advance their anatomical knowledge, an opportunity that was not available to midwives, or to women (Dahl 2001).

The promotion of man-midwives did not go without challenge, Elizabeth Nihell (a midwife writer of the 18th century (Murphy-Lawless 1998) and Jane Sharp, in their writings, made claims that the role of the midwife had been given to women by God, a tradition that was natural and in which men had no place interfering. In order to counteract this, the rhetoric of the man-midwives also drew from 'nature' suggesting that they had the natural capacity for learning and training needed for birth, learning that was deemed to be beyond the capabilities of women (Dahl 2001). This view was in keeping with the wider-held views in relation to women at the time. Rather than support an increase in the education for midwives, man-midwives established themselves as the appropriate practitioners for difficult births and developed the language and expertise to support this role (McIntosh 2012). So established was their role by the late 19th century, it had become fashionable to engage a male practitioner during childbirth (Drife 2002). The engagement of a man-midwife was embraced by women (and their families), reflecting two particular aspects of their so-called social status of wealth and learning. It highlighted, firstly, that you had the financial means to pay the fees of a male birth attendant (Capp 2003). It also demonstrated that you supported and preferenced this new scientific expert whose knowledge was in-keeping with the ideas of the Enlightenment era - science and medicine viewed as the vanguards of progress (Shelton 2012).

Loudon (2008) makes reference to the fact that the man-midwives had to make a living, and so patriarchal biases and gendered assumptions that excluded traditional midwives from formal education increased the position and fashionable acceptance of man-midwives in lucrative practices. Murphy-Lawless (1998) asserts that the nature of the state regulation of midwives, which followed in the 20th century, added to their position and so

placed man-midwives (now obstetricians) and midwives in professional competition with one another.

3.2.3 The Registration and Regulation of Midwives

The end of the 19th and start of the 20th century saw midwives attempt to maintain (or regain) their status and, for this end, lobby for formalised education, training and regulation (McCourt and Dykes 2009). The Church licensing of the late 16th century declined over the 19th century, as licenses were expensive and so most midwives did not have one (Marland 1993). McIntosh (2012) describes the erratic attempts by the male-midwives in some lying-in hospitals of the early 19th century to develop training for midwives. The ‘successes’ of these attempts are difficult to ascertain, as historical records do not differentiate between midwives who received a formal education and the previously described local women/lay midwives (McIntosh 1998). Some texts suggest that this interest in the education of midwives did not serve to advance the skills of midwifery but rather to stretch the influence of obstetric medicine to rural areas of the UK (Lindemann 2010). These areas offered little financial reward and the emerging obstetricians seemed content to leave the midwives or the non-specialised doctors (and General Practitioners (GPs)) to support these women. However, it would appear that the male practitioners maintained an influence, and so a control, on the formal education these practitioners received (King 2007).

The call for regulation was not without controversy nor was it considered to be agenda-free. McIntosh (2012) suggests that it was not just midwives wishing for more formal organisation, the profession of obstetrics also became involved in an effort to define the role of the midwife and so secure their own place within childbirth. The regulation of midwives is recorded as a two-edged sword; whilst initiated by midwives in an attempt to compete with the science of obstetrics (McCourt and Dykes 2009), regulation and licensing was also seen as limiting the role of the midwife (Fahy et al 2008). A review of midwifery registration at the end of the 19th century was undertaken by Australian sociologist Evan Willis. Willis (1983) highlights that the medical profession was divided in its opinion in relation to

midwifery registration. In general, concerns were raised in relation to the competence of midwives, who were held responsible for the high rates of maternal death of the time (Donnison 1977). These concerns were used as an argument by some obstetricians to suggest that midwifery should be outlawed. Other members of the medical community suggested that midwifery needed to be redefined and supervised by doctors (McIntosh 2012). Those obstetricians in favour of registration played an influential role in the demarcation of childbirth into 'normal' and 'abnormal', resulting in the restriction of the midwives' scope of practice to normal birth (Murphy-Lawless 1998). Witz (1992) suggests that, while obstetric doctors in the UK tolerated the division, this was in contrast to those in North America who believed that normal and abnormal birth could not be distinguished, therefore midwifery could not exist as a separate profession (Arney 1982). For midwives in North America and Canada, this led to obstetricians taking over childbirth, outlawing midwifery and an ongoing struggle against midwives that continues to this day (Davis-Floyd 2005).

The Midwives Act of England and Wales came into effect in 1902; this was later adopted in Scotland in 1915 and in Ireland in 1918 (McMahon 2000). The Act legislated in relation to who could, in a professional capacity, attend a birth and restricted this to doctors or midwives (or students of either group). 'Midwives' were identified as those who registered with The Central Midwives Board and met the prerequisite education requirements and standards. This disciplinary system of regulation eliminated the traditional midwives who lacked formal training (McCourt and Dykes 2009). The elimination did not happen immediately, there was a lead-in period during which midwives were given time and opportunity to avail of the formal education required, therefore "bona fide" midwives continued to work in the community alongside registered midwives. Women's financial situations influenced which 'type' of midwife they engaged, as registered midwives charged a higher fee for their services. Sargent (2002) suggests that, with time, friction between the different groups of midwives emerged, and the holistic, traditional approach to midwifery was discredited by midwives who became formally educated and skilled in supporting birth in hospital. This mirrors the marginalisation that female midwives experienced

from the man-midwives who devalued their skills and knowledge during the 18th and 19th centuries. The elimination of midwives without formal training meant that the UK and Ireland did not develop the counter-culture of homebirth midwives noted in North America. The terms *Granny Midwives*, *Direct Entry Midwives*, *Lay Midwives* are used interchangeably throughout the literature; regardless of the title these unlicensed midwives were excluded from mainstream healthcare and viewed as a radical alternative to obstetric-led care. Although 27 States in North America now regulate and licence midwives, some remain unlicensed, the fear of regulation bringing their practices closer to doctors outweighing the threat of prosecution (Cheyney et al 2014a).

Midwives in the UK, Ireland and other countries of Europe were not unanimous in their support of regulation and registration. For some midwives it was a simple case of agreeing to the terms of registration in order to secure work legally (McMahon 2000). Other midwives who supported it did so in the belief that registration enabled them to maintain a degree of autonomy in relation to normal birth (Witz 1992). However, professional autonomy was elusive given that the Central Midwives Board, which oversaw the examining and registration of midwives, was controlled by the medical profession (Witz 1992). Therefore obstetricians controlled the level of knowledge and competence deemed necessary for a midwife and the level of education needed to reach those standards. The normal/abnormal interface was also problematic; the late 19th and the 20th centuries saw obstetric knowledge inform the definition of normal, with the labels 'normality' or 'abnormality' awarded in retrospect (Murphy-Lawless 1998). Witz (1992) viewed this demarcation of normal/abnormal as a strategy used by the medical profession to control another professional group whose practices overlapped. The influence of the man-midwives and their scientific knowledge led the socially constructed reality in relation to normality and abnormality and further enhanced the position of power they held within childbirth.

Tuchman (2005) presents a different argument in relation to the impact that regulation had on the profession of midwifery. She suggests that portraying

midwives as a casualty of the alliance between state regulation and the profession of medicine is but one way of critiquing the history. An alternative interpretation views midwives in some European jurisdictions as “beneficiaries of a state’s protectionist policies” (Tuchman 2005, p. 23), which enabled them to resist the elimination by obstetrics that had occurred in the US. While this goes some way to providing an explanation for the higher status of midwives in some countries (e.g. the Netherlands versus North America) it does not lessen the impact of “*the professional strategies of male practitioners in modern Europe to confine the role of the midwife to that of mere attendants at the birth while they equipped themselves for interventions into abnormal births*” (Turner 1995 p. 89). These historical changes in relation to birth have left a legacy in relation to the competing interests of obstetricians and midwives that remain unresolved in many jurisdictions today.

The historical changes described thus far set in place a change in authority over birth and birthing practices. Man-midwives aligned themselves to the sciences in an attempt to legitimise their existence and so diminish that of the traditional midwives. By distancing themselves from female midwives and differentiating their roles, man-midwives carved out a professional framework for obstetric discourse that influenced, and continues to influence, the concept of normal birth. Recasting birth as a medical rather than a social or biological event with changes in the connotations of *normal* and *abnormal* birth had implications for the way childbirth was culturally defined, valued and organised (van Teijlingen 2005).

3.2.4 Reconstructing Birth as a Medical Event

The 20th century and the cultural changes that occurred therein saw the growing obstetric profession as indispensable to birth. The separation of normality and childbirth, and defining normality only in retrospect (Percival 1970) altered completely the cultural understandings of birth; in short, birth became characterised as an illness and was pathologised (Wagner 1994). American medical and cultural anthropologist Robbie Davis-Floyd suggests that this undermined women’s bodies, reducing them to ‘*barriers to be overcome*’, with the female body portrayed as imperfect and incompetent

(Davis-Floyd 1994). Men's perception of a female body that did not function perfectly was deemed convenient by Mander and Murphy-Lawless (2013), in that it justified men's existence and role in taking over childbirth. The change in attitude to women's bodies during birth suggested that they could no longer be trusted to birth, and with childbirth came uncertainty (Lupton 1999). In an effort to minimise this uncertainty, pregnancy and birth became separated from everyday life and required medical intervention within a clinical environment. This belief became entrenched in the fabric of society (Lupton 1999). This change in relation to the understanding of birth did not occur in a vacuum, but is linked to the wider discourse of risk associated with modernity. In turn this added weight to the notion that no longer could midwives be left to *manage* birth, rather a medical presence was needed (Murphy-Lawless 1998, Donnison 1988). This transformation and reconstruction of birth within the context of obstetric discourse cemented the hegemonic professional control of obstetrics (Wagner 1994). The 20th century saw birth, which traditionally was regarded as a natural life event, the province of women, become problematised, pathologised (Oakley 1984, van Teijlingen et al 2004), and 'corrected' by the use of intervention, technology and relocation in hospital (Davis-Floyd 2005). Feminist critiques of the history of childbirth and models of maternity care suggest that this reinforced the *struggle* between obstetrics (men) and midwifery (women) (Oakley 1993, Murphy-Lawless 1998). The polarisation of views in relation to pregnancy and birth and the definition and implications of 'normal/abnormal' (which continues in the current provision of maternity services in Ireland) was magnified (Lupton 1999, Jordan 1993, Davis-Floyd 2005, Edwards and Murphy-Lawless 2006).

The success of the medical authority around childbirth can be clearly seen in the move of birth from the home to hospital, a phenomenon that occurred across the countries of the Western world with the exception perhaps of the Netherlands (Davis-Floyd & Cheyney 2009). The relocating of birth was intertwined with the technological revolution and the manner in which obstetricians suggested that their skills and technological expertise could minimise and control the uncertainty they associated with childbirth

(Murphy-Lawless 1998). The organisation of modern maternity hospitals and units was influenced by the wider social changes of the 20th century, namely urbanisation and industrialisation (Wagner 2001). Although the industrial revolution is recorded in the late 18th and early 20th centuries, McIntosh (2012) suggests that its impact on the organisation of maternity care was most clearly seen from the postwar era of the 20th century. Birth was relocated to institutions akin to production lines, where McCourt and Dykes (2009) note that birth was managed and controlled, interventions to ensure efficiency of birth were performed as routine (e.g. episiotomy, induction of labour, augmentation of labour). Martin (1987) suggests that women's bodies were broken down into the sum of their mechanical parts and so isolated according to their function and corrected with the use of technology. Walsh (2004) and McCourt (2009) draw from the industrial model of production as most famously noted by Henry Ford's car production line – Fordism, where the production of a car was divided into its component parts and manufacturing each part was undertaken separately by individual workers who had a clearly defined role. McCourt (2009), drawing on Foucault's analysis of power names the obstetrician as the manager, the midwife as the worker, the mother as the machine and the baby as the end product within this analogy. Coined the *industrial model of birth* (Begley et al 2009) birth was now located within hospitals where it could be managed, timed and corrected with the use of intervention and advancing technology. In tandem with this change in focus, the end product, or baby, was viewed as a commodity that was required to be produced to a high level of quality (Martin 1987). Fetal and neonatal outcomes thus began to be seen as important measures of quality care, in addition to data on maternal mortality.

This scientific reading of birth concerned with measurement did not acknowledge the social and emotional aspects of women or of birth, which had been central to the traditional model of midwifery. Interventions in childbirth and the use of developing techniques, which may have been useful and appropriate for some women, became the norm (Mccourt and Dykes 2009). The impact of this was not fully appreciated until they had become routine aspects of care by which time the medicalisation of birth

had become embedded in the culture of birth of the Western world (Oakely 1984). The argument in favour of hospital birth was intensified by European governments of the 1970s stating that hospital was the 'safest' place for birth (e.g. Peel Report (1970) in the UK, Comharile na n-Ospidéal (1976) in Ireland). The impact that this had on birth in Ireland and the choices available to women will be explored in Chapter 4. All done in the name of safety, this technocratic model of care came to affect the understanding of birth and fundamentally reconceptualise how normal childbirth was perceived.

Feminist readings of the historical and cultural shifts in relation to birth, argue that women were largely passive in changes in relation to the way birth was understood and organised (Oakley 1976). It is frequently characterised as a story of coercion where women (and midwives) lost control of their bodies, their place of birth and the traditions of female support that occurred therein (Martin 1987). Leap and Hunter (1993) suggest that this underplays the role women held in embracing the developments of obstetric medicine (e.g. the predictability, pain management - epidural anesthesia, the claims in relation to guaranteeing safety). Only a minority of women questioned initially the rhetoric of obstetricians and medicalised birth, and the influences of these voices will be explored in Chapter 4. The part midwives played in these events is also complex, given that the developments previously described undermined midwives' autonomy and limited their role.

3.2.5 The Role of the Midwife in the Obstetric Model of Birth

The Midwives Act of England and Wales (1902) and the subsequent Acts of Scotland and Ireland were charged with laying the foundations for the regulation of midwifery practice (McIntosh 2012). The reconstruction of birth within an obstetric model of care and the subsequent move of birth to hospital is held as changing the role of the midwife and the manner in which midwifery care was organised (Tew 1998). Some midwives in the UK continued to practise within their communities; however, their role was constrained over time as a reorganisation of the maternity services meant that community midwives were, from the 1970s, for the most part,

employed by the hospitals within the National Health Service (Robinson 1990).²⁰ Midwives were necessary to meet the needs of the growing maternity units and maternity hospitals. To support this end their work was organised around shift patterns and allocations to hospital wards (which now divided pregnancy and labour, for convenience, into antenatal, postnatal and labour) rather than the lives of women (McCourt and Dykes 2009). Hunt and Symonds (1995) describe this as destructive to midwives; not only had they to leave the tradition of being part of the community, but the manner in which hospitals were organised meant that care was now fragmented. McIntosh (2012) suggests that midwives were now more akin to industrial workers than the craftswomen of the previous centuries whose role had been central to, and organised around, women's lives.

The move to hospital also saw midwives practise alongside obstetric doctors. As obstetricians had embraced and established their role as the expert, focusing their scientific knowledge on 'managing' birth, Kirkham (1996) suggests that midwives had to re-establish themselves and did so as the provider of emotional care. These skills were borrowed from nursing (who had a longer history of working in a hospital environment where doctors were viewed as the expert) and were seen as a 'follow-up' role to deal with the emotional needs of women after doctors had attended to their physical ones (Walsh 2004). Midwives also borrowed structures and hierarchical task-orientated practices, which governed nursing at the time (Page 2008). The role of the midwife also altered in that they had boundaries in relation to their place within normal and abnormal birth and had a regulatory obligation to refer to an obstetrician when a deviation from normal was noted. It was crucial that midwives recognised their scope of practice within this statutory framework (Edwards & Murphy-Lawless 2006). Once referral to a doctor was made, Symonds and Hunt (1996) state that the role of the midwife became more in keeping with that of an obstetric nurse working under the direction of an obstetrician. Ultimate disciplinary control was now viewed to be in the hands of medicine

²⁰ While community midwifery continued in the UK, in Ireland it became all but extinct (Robins 2000).

(McCourt & Dykes 2009), with doctors setting the parameters for the definitions of normal and abnormal (Scamell & Alaszewski 2012).

Ireland did not stand outside this evolution of obstetrics and midwifery and, in fact, Irish obstetricians made a considerable contribution to the cultural shifts in relation to the birth within Western countries. This contribution is evident in the development of the Active Management of Labour package of care. Issues that relate specifically to the understanding of birth in Ireland will be explored and will provide a cultural and contextual background to this study.

3.3 The Culture and Context of Birth in Ireland

As noted at the start of this chapter, the cultural changes that occurred in Europe in relation to the organisation of birth, especially those in the UK (such as the rise of man-midwives, the increase in medicalisation, and the regulation of midwives); have impacted on and influenced how birth is understood in Ireland. However, there are specific historical events that demonstrate how Ireland reacted to and supported the emergence of obstetric discourse and the professional regulation of midwives. The following sections provide a critique of the impact that these historical occurrences had on the reading of birth in Ireland and on the unique organisation of the maternity services.

3.3.1 The Medicalisation of Birth in Ireland

Prior to the 20th century and the regulation of midwifery practice, birth in Ireland was organised in similar manner to most of Europe. Birth for women in Ireland was also located in the community, at home supported by local midwives with varied competence and skills inherited from an apprenticeship-type training (McMahon 2000). Robins (2000) in his “Review of the Irish Nurse²¹ in the early 1900’s” suggests that these women were viewed as “*the fount of all knowledge*” (p. 15), part of the traditions of childbirth intertwined within the fabric of society in Ireland at that time. Although The Dispensary System (1851) (under the Poor Law System of

²¹ Robins includes nurse and midwife under the title of ‘nurse’ in his writing.

1838²²) saw the appointment of district doctors and midwives, the 'midwives' remained poorly paid and mostly untrained in the formal sense and so this had no real impact on the way midwifery care was organised in rural areas (Kennedy 2002). The Midwives (Ireland) Act 1918 barred unqualified women from practising as midwives, yet prosecutions of 'lay women' are recorded up to the 1930s (Kavanagh 2005). Robins (2000) suggests that this was because many families did not want to break with the old tradition, and wished to be attended by the same midwife that they had had for previous births. Perhaps another suggestion is that women could not afford the fee required to engage a registered midwife. Voluntary hospitals offered services to the poor women of urban areas, primarily in the growing city of Dublin (Murphy-Lawless 1998). These hospitals initially provided the 'district' around them with community midwifery, which included the provision of homebirth (Browne 1995). Therefore a tradition of organised community midwifery did exist in Ireland at the start of the 20th century, a tradition that died out over a very short space of time, mainly due to the introduction of the Mother and Infant Care Scheme (see below).

The emergence of the Irish State in 1922 preceded the development of the National Health Service in the UK. This is suggested as the reason why very different maternity services developed in the two countries thereafter, Ireland lacking the tradition of free midwifery services for all (Wren 2003). Whilst maternity care was free for all women in UK, the provision of care in Ireland was influenced by geography and economics (midwives attended women at home in rural areas, voluntary hospitals offered services to the poor women of urban areas and doctors (mainly General Practitioners, GPs) provided private care to the country's 'wealthy' women in their own homes or in private 'maternity nursing' homes (Kennedy 2002). The foundation of the Department of Health in 1947 and legislative 'health' initiatives that followed had a marked impact on the demise of community midwifery and birth at home and on the organisation of the maternity services in Ireland (Robins 2000). The shift from home to hospital birth in Ireland is

²² Poor Law System – Acts of Parliament to address widespread poverty in Ireland
<http://www.nationalarchives.ie/research/research-guides-and-articles/guide-to-the-records-of-the-poor-law/>

inextricably linked to Noel Browne (Minister for Health, 1940s) and the introduction of the Mother and Infant Care Scheme (MICS). Minister Browne (who was a medical doctor) recounts in his memoir his attempts to provide free maternity care for all, which was operationalised through the Mother and Infant Care Scheme (Browne 1986). Proposed by the 1947 Health Act, the scheme was not implemented until the 1953 Health Act due to the objections of the Catholic Church and the medical community²³ (Browne 1986). The objections of the former were based on the principle of subsidiarity, in that the Catholic Church was concerned that this would set a precedent for the State's interference in matters of reproduction and contraception, which is better (according to the Church) left in the hands of the individual conscience guided by their religion/faith (Kennedy 2004). It is surmised by Browne himself that the medical community feared a free scheme would mean a loss of private incomes generated by 'attending' women during their childbirth experiences (Browne 1986). Such was the influence and power of these objections that concessions to Browne's initial proposal ensured that there was an element of means testing associated with the scheme. This was not amended until as recently as the 1991 Health Act when free maternity care for all women finally became a statutory provision. Wren (2003) suggests that women in Ireland had, by then, become used to the idea of paying for private maternity care. This is reflected in the number of women in the current provision of the maternity services who access private care/semi-private care from obstetricians, paying for care in spite of a state sponsored maternity service.

Whilst means tested, the 1953 scheme claimed to offer women the opportunity of full maternity care with a choice of doctor or midwife, (the payment of additional monies enabled women to attend a hospital or a maternity nursing home of their choosing (Kennedy 2002, 2004). Yet this is not explicit given that maternity care is recorded in the scheme's contract as being offered by a GP and hospital doctor – there is no mention of midwives or provision for any model of midwife-led care (O'Connor 1992, 1995). The Mother and Infant Care Scheme thus placed doctors

²³ Browne resigned over this issue, his attempts to provide free care deemed by many as a failure

(obstetricians and GPs) in Ireland as pivotal to the maternity services; receiving payments from the state for care offered to the poor whilst still earning a private income from women who had the money to pay. The trend toward hospital care can be traced to this state sponsored maternity service for two reasons. In spite of the means testing element of the scheme, for the lower income families, care in hospital cost considerably less than that paid to nursing homes, this was of major influence in the 1940s and 1950s climate of economic deprivation (Kennedy 2002). Historically, obstetricians received a basic salary from the Department of Health and Children but had the freedom to earn money through private practice above and beyond their commitment to the state (Wren 2003). This changed in the consultant contracts issued from November 2012. The new contracts saw an increase in their working hours within the public sector and a specific ratio of public to private practice was stipulated.

The social status and role of women in Ireland at this time also needs to be considered. Post independence the newly emerged Republic of Ireland of 1922 has been described as an isolated and traditional society (Kennedy 2002). Shaped by the social constructs of gender, women were subservient to the patriarchal structures, most especially those of the Church and the State. The woman's place was very much considered to be at home, as a wife and a mother as is demonstrated in the Constitution of 1937, which echoed the Papal teaching of the time (Kennedy 2002). This was promoted in legislation (e.g. restrictive employment practices such as the 'marriage bar' of 1929-1973, which enforced immediate job loss on marriage), the Catholic Church and the State were united in defining this position and enforcing this gendered ideology; women therefore for the most part did not have a voice, or an influence, outside their home. (Kennedy 2001). Scheff (2000) proposes that the German phrase, which originated in the 1890s, '*die Küche, die Kirche, die Kinder*' (kitchen, church and children) describes appropriately the position of women in Europe in the late 19th and early 20th centuries, thus rendering them without social power to challenge or change the patriarchal system. Several examples in Irish history clearly demonstrate the austere control of women and their reproduction – the use of symphysiotomy, mainly in the 1950s and 1960s but with cases recorded up

until 1984 (O'Connor 2011, Walsh 2013), the absence of family planning or contraception (not only was contraception illegal, offering contraceptive advice was liable to prosecution)²⁴, and the more recent abuse of peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda (1974 – 1998) (Government of Ireland 2006). Other examples of restrictive policies in relation to women include the appalling treatment suffered by young women in Ireland who became pregnant outside marriage (Costigan 2005). The majority of these young girls and women were disowned by their families and were taken into ‘mother and baby’ homes where they were given food and shelter in return for hard manual labour. They birthed their babies in the home, with a high risk of death to the babies and themselves (twice as many babies died in these homes as in other areas of Ireland) (Luddy 2011). Their babies were then taken from them and sent for adoption without, in most instances, any records being kept (Millar 2003). As abortion was illegal in Ireland until recent times (and is still only available under very tight restrictions), women who wished to terminate their pregnancies were forced to travel to the UK or resort to ‘back street’ abortionists (Kavanagh 2005). While an exploration of these examples is beyond the remit of this chapter, they are noted in order to draw attention to the role the Church, the State and the medical profession played in influencing social policy and so controlling *women’s business*. Other policies women inherited – e.g. the Mother and Infant Care Scheme (explored earlier in this section) and Active Management of Labour, played a significant and long lasting role in influencing the organisation and provision of maternity care in Ireland.

Table 1: Numbers of Live Births in Ireland (1923 – 1985)

Year	Live Births
1923	62,417
1925	62,069
1935	58,353

²⁴ The Family Planning Act was finally introduced in 1979, allowing contraception on prescription to married couples only (Kennedy 2002)

1940	58,226
1945	56,594
1950	63,565
1955	61,622
1960	60, 735
1965	63,525
1970	64,382
1975	67,178
1980	74,064

The Central Statistics Office (CSO)

The increase in the birth rate noted in Ireland (Table 1) and the increasing numbers of women birthing in hospital, due to the introduction of the MICS (Table 2) placed pressure on institutions to cope with activity levels over and above that for which they were designed. As a ‘solution’ to this increased demand on the labour wards of maternity hospitals the Active Management of Labour package emerged from the National Maternity Hospital, Dublin in the 1960s. It appears that a reliance on the interventions associated with Active Management of Labour occurred in order to decrease the length and costs of women’s labours and increase the throughput of over-active hospital labour wards (O’Driscoll et al 2003). Opponents of the package accuse this so-called efficiency in service provision of being driven by obstetric and economic models where no space for individualised care or choice for women exists (please see the critiques of Active Management of Labour offered by Goer 1995, Murphy-Lawless 1998, Mander 2001, Downe & Dykes 2009). Yet Active Management of Labour was taken on board in varying degrees by all maternity hospitals in Ireland and set the tone for the dominance the obstetric model continues to maintain over childbirth in Ireland (Begley et al 2009). Murphy-Lawless (1998) notes that this obstetric control was facilitated by subsequent government policy in service planning and the delivery of maternity care. In 1976 a group of obstetricians were commissioned by the Department of Health to review the size of maternity units and obstetric cover. The report - The Discussion Document on the Development of Maternity Services (Comharile na n-Ospidéal 1976) did

little to dispel an exodus from home to hospital based care (Murphy-Lawless 1998). This report recommended that all women should birth in a consultant- staffed obstetric unit. Increased centralisation and larger maternity units were deemed necessary to facilitate obstetric training (Comharile na n-Ospidéal 1976). It must be noted that the evidence, if any, underpinning the recommendation is not explicit. Some anecdotal discussion would suggest that these recommendations were based on a wildly held assumption that development of hospital obstetric-led services was responsible for the rapid decline in maternal and perinatal mortality. This belief does not take into account increases in living standards (nutrition), in housing and in sanitation associated with that era (Delaney et al 2011). This idea has been challenged in other countries e.g. Tew (1998) reasoned that the rationale for lower perinatal mortality rates in the UK was not directly related to the hospitalisation of birth (as encouraged by the Peel Report in 1977) but rather as a result of the improvements in public health, which happened to occur during the same time period. Maternity hospitals were now charged by the State to provide maternity care to all, resulting in hospitals with limited resources and capacity.

Table 2: Place of Birth in Ireland (1955 - 2012) (ESRI)

Year	Number of Births	Number of planned home births	%
1955	61,662	20,665	33.5
1970	64,382	1,883	3
1980	74,064	202	0.3
1990	52,793	240	0.45
2000	54,858	216	0.423
2005	61,408	183	0.208
2010	75,600	177	0.234
2012	71,986	176	0.2

Following a review of trends in the numbers of women opting to birth in hospital (Table 2) it would appear that these recommendations, with their unsupported rationale, were fully embraced. Under a policy of centralisation in keeping with the proposals of Comharile na n-Ospidéal (1976) the closing of community-based services, maternity nursing homes and small maternity units ensued; the centralisation of maternity services continued (Murphy-Lawless 1998) and shaped the landscape of maternity care in Ireland as we now know it.

Alongside the movement of birth from home to hospital, the medicalisation of birth became a defining feature of the maternity services in Ireland (O'Malley 2002). This is most clearly demonstrated by the aforementioned Active Management of Labour with its emphasis on a strict protocol of measuring and timing the onset and 'progress' of labour; early augmentation with the acceleration of labour deemed necessary to circumvent "insufficient uterine action" (Downe & Dykes 2009). The "cascades of intervention" (Inch 1986), which were deemed to offer a 'solution' to the capacity crisis of the maternity services in Ireland in the 1960s continue today and continue to render maternity hospitals akin to factory production lines where women and labour are expected to conform to norms with the use of complex forms of surveillance (Stevens 2009). OBoyle in his ethnography of Independent Midwifery²⁵ in Ireland (OBoyle 2009) states that –

"a combination of social, cultural and political factors have constructed to make Ireland a model of centralised and interventionist maternity services" (p. 19).

These factors have played an influential role in defining birth in Ireland and outlining what is considered and accepted as *'the norm'* in Irish maternity care. Women, for the most part, are required to fit into a predefined model of maternity care, located in hospital and underpinned by a philosophy that views birth as problematic and places an emphasis on the elimination of risk through intervention (Devane & Begley 2004). Consequently, as noted by Marsden Wagner (Former Director of Women's and Children's Health at

²⁵ The title used by SECMs in Ireland prior to 2008 and the issue of the MOU

the World Health Organisation) maternity care in Ireland has evolved into a model described as –

“highly medicalised, high-tech, doctor-centred, midwife marginalised care”

Wagner (2001, p. S26).

This sets the background to explain the demise of true midwifery practice, and home birth, in present-day Ireland.

3.3.2 The Invisibility of Midwifery in Ireland

Midwifery and the role of the midwife in Ireland requires specific attention within this thesis to provide cultural and contextual understanding in relation to the role of the midwife in birth and how this is influenced by the organisation of the maternity services. In a similar vein to other countries, the role of the midwife from the 20th century was limited by obstetric dominance; however, midwives in Ireland also had to contend with attempts to subsume them under the umbrella of nursing (Kennedy 2004). Historically, midwives were registered under The Midwives (Ireland) Act of 1918 and had their own regulatory board – The Central Midwives Board for Ireland, from 1918 until 1951 (McMahon 2000). As noted in the previous section, in relation to the organisation of the maternity services in Ireland, the fundamental differences that exist between midwifery in the UK and Ireland can be traced back to legislative changes in Ireland after the Republic of Ireland was established in 1922. It appears that post-registration, midwives in the UK aligned themselves with nursing in order to strength their existence against the medical profession, but in doing so they still maintained their identity (Robinson and Thomson 1994); midwifery in Ireland did not have the same success in relation to preserving their uniqueness.

Under the Nurses Act of 1950 (Matthews 2006), The Central Midwives Board was abolished and regulation of midwives became the responsibility of the Statutory Midwives Committee of the newly established An Bord Altranais (The *Nursing* Board), which amalgamated the previously separate governing bodies of Midwifery and Nursing in Ireland (Matthews 2006). Historiographies of the health services and health care professionals in

Ireland tend to conflate nursing and midwifery (e.g. Leahy and Wiley (1998), O'Dwyer and Mulhall (2000), Robins (2000), Fealy (2005). While this could be as a result of the statutory regulation of the professions from the 1950s, it is also reflective of the cultural view taken in Ireland in relation to the profession of midwifery and how it became akin to obstetric nursing. It was proposed in the draft of the 1950 Act that the word midwife be replaced by the term 'maternity nurse'; this was contested, and an amendment to retain the title 'midwife' appears to have been accepted, to ensure that recognition of qualifications and reciprocity of registration with England continued (Matthews 2006). Unfortunately, however, the draft Act merely had some text altered, rather than undergo a full amendment. In the process, a phrase that had read 'maternity nurse means midwife' was altered to read 'nurse means midwife', a phrase that was used for the following 60 years to challenge any claims of the midwifery profession to be autonomous (Matthews 2006). The Department of Health thus did not view midwifery as a distinct profession and did not legislate to uphold its uniqueness or difference. Whilst not made illegal as was the case in North America and Canada, midwifery in Ireland became subsumed as a discipline (or specialty) of nursing. Under the 1985 Nurses Act, The Statutory Midwives Committee was abolished leaving midwives and midwifery in Ireland entirely under the regulation of the previously noted *Nursing* Board with only *ad hoc* midwifery committees to represent them (Matthews 2006). Limiting the midwifery profession's right to self-regulation and the attempts made by the then legislators to subsume midwifery under the profession of nursing occurred alongside the centralisation of maternity services (Murphy-Lawless 1998). The impact of one on the other cannot go unnoticed. From 1950 until 2011, midwives in Ireland experienced regulation within the philosophy of the nursing profession and for the most part, were placed within hospital environments where care was managed and led by obstetricians. The claims to autonomy espoused by midwives, which is perceived as lacking in the nursing profession, must be called into question here. This loss in midwifery autonomy, the now subordination of midwifery is held as one reason midwives in Ireland appeared to be complicit in, or at the very least muted in, their response to the medicalisation of birth and the effect this has had on diminishing options for

women in relation to models of care and place of birth. (The attempts of some midwives to reassert their role and the implications this has for women in Ireland will be explored in chapter 4).

The latest consideration of the legislation regarding the nursing and midwifery professions in Ireland was enacted in the 'new' Nurses and Midwives Act (Government of Ireland 2011). The long awaited Act recognises midwifery as a distinct and separate profession (The Commission on Nursing Report recommended a separate recognition of midwifery in 1998, (Government of Ireland 1998). The Act legislated for the formation of a Midwives Committee, which will advise the newly named Irish Nursing and Midwifery Board²⁶. While these changes are viewed as positive for the profession of midwifery, some critics suggest that they do not go far enough in relation to self-governing (Mander and Murphy-Lawless 2013). The Midwifery Committee will report to the Board and they may 'consider' their advice. Midwives and women sought an amendment to include that the decision of the committee has binding effect thus ensuring that midwives have professional self-governing rights, but this failed (OBoyle 2010). It is suggested by Symon (2011) that this ignores the Health and Social Care Professional Act 2005 which gave 12 professional groups (including physiotherapists, radiographers, social workers, dieticians) self-governing status (with input from some outside their profession).

Midwifery education and the way in which it is organised also has an integral influence on the development of the professional identity of midwives (McIntosh 2012). In the Netherlands and the UK, mainstream midwifery education has always included a pathway for midwives who were not nurses (Direct Entry Midwifery). This is in contrast to states of North America where midwifery was outlawed and the tradition of *lay midwives* emerged, where women illegally supported each other during home birth in an attempt to preserve and maintain natural birth (Davis-Floyd 2003). Under the Midwives (Ireland) Act of 1918, a dual entry point to the registration of midwives existed in that a 3-month training to register was undertaken by nurses and a 6-month for non-nurses (this increased to 6

²⁶ An Bord Altranais agus Cnáimhseachais na hÉireann

months and a year respectively during the 1920s) (Kennedy 2002). This continued until 1959 when its demise was influenced by a combination of the regulation of midwives by the profession of nursing and the decreasing numbers of women having a home birth (McMahon 2005). Matthews (2006) in her historical review of midwifery autonomy in Ireland, proposes that the separate training for midwives (once they were qualified nurses) was under threat in the mid 1950s and very much mirrored the argument for the replacement of the term 'midwife' with 'maternity nurse' within the Nurses Act of 1950. Again, recognition of qualifications and reciprocity of registration with England appeared to be the factor that prevented the introduction of a single nurse/midwife education programme and one point of entry to registration for a nurse/midwife. It would seem the tradition of Irish midwives immigrating to the UK to secure employment was of influence in maintaining a semblance of distinct midwifery education and registration. From 1960 until 2003 all midwives educated in Ireland first qualified as nurses, undertaking a three-year certificate/diploma programme followed by one/two years of midwifery (apprenticeship-style) training. Over the course of nearly 50 years, this initial indoctrination in nursing meant that midwives educated and trained in Ireland were steeped in a philosophy of illness which required medical intervention (Carroll and Begley 2003). There was also a variation in the reasons as to why nurses became midwives. Anecdotal recall suggests that many viewed it as an additional qualification that was considered desirable, or sometimes essential, for employment in hospitals outside the city of Dublin, as regional hospitals were not maternity-specific but had maternity units as part of the larger general hospital. Having a dual qualification meant that midwives could be placed to *work* in any area of the hospital in order to meet the needs of the service. Midwifery was also considered 'necessary' for nurses who wanted to work in Accident and Emergency departments, and for those who wished to move up the career ladder into management positions; this was an implicit tradition, not an explicit requirement. Up until 2007 midwifery registration was a prerequisite for the programme for public health nursing. Midwifery was, therefore, undertaken by many to meet these needs and while it is difficult to speculate the number of nurses who '*did*' midwifery for reasons outside the interest and desire to be a midwife, the

effect this had on the identity of the profession and how midwives viewed themselves must be considered. The impact this had on the acceptance of the obstetric-led model of maternity care and on midwives referring to doctors for decisions in relation to maternity care must also be taken into account.

The requirement for a midwife in Ireland to 'be a nurse first' was withdrawn over a decade ago. A three-year 'direct entry' diploma in midwifery pilot programme was commissioned by the Department of Health and set up in Trinity College Dublin in 2000 and a four-year 'direct entry' degree programme commenced nationally in 2006. Murphy-Lawless (2011) suggests that this rise in *direct entry* midwives serves to strengthen the discrete identity of midwifery and will argue against any move to integrate nursing and midwifery education as is experienced in the education of obstetric nurses. In turn this is viewed as an opportunity to educate a cohort of midwives who are not influenced by the nurse's subservient relationship to doctors or embedded in the medical model of illness and intervention. However, this aspiration is easily challenged given the dominant role of obstetrics in the maternity services in Ireland and the manner in which care, for the most part, is offered as hospital-based and obstetric-led.

3.4 Summary

The concept of birth is culturally framed and influenced by professional interpretations. This chapter provides a cultural critique that explores these professional interpretations, the evolvment and dominance of medical knowledge and the manner in which this influenced cultural transitions. The implications of the cultural interpretations of birth are relevant to this study; drawing out the contextual features and nuances highlights how the medicalisation of birth and the technocratic model of maternity care become entrenched in the fabric of society and shaped the current provision of maternity services in Ireland (Murphy-Lawless 1998). It also draws attention to the dominant discourse of childbirth and how the control by man-midwives and obstetricians has shaped this and, subsequently, the role of the midwife. These changes are influenced by the intermingled stories of

the emergence of obstetric medicine, midwifery regulation and the re-conceptualisation of birth and the technological revolution.

The next chapter will explore some of the socio-cultural theories that supported and continue to sustain this discourse and those that challenge obstetric hegemony and the impact that these narratives have on place of birth.

Chapter Four: Discourses in Maternity Care and Influences on Place of Birth

4.1 Introduction

Chapter three provided an account of the historical changes in childbirth that were marked by a cultural shift in the understanding of birth, which witnessed an unquestioning acceptance of the unrelenting medicalisation of childbirth within the societies of the Western world. While birth in hospital may be considered the norm in Ireland, women struggle with a system that has emerged with the centralisation of services (Murphy-Lawless 2011). Since the 1990s Ireland has experienced a steady increase in birth rates, with little change to the infrastructural capacity of maternity hospitals or increase in the number of midwives in the service (Begley et al 2009). Although Dublin's three large tertiary hospitals were all founded in the 1700-1800s, new premises were built in 1967 for the Coombe Hospital, and refurbishments and enlargement of the other two sites took place in the same decade. However, since then there has been little development. Women find themselves on a specific pathway because of the limited resources and space, in a 'conveyer belt' system where lack of choice, high intervention rates, and acceleration of labours have become normalised in a health service struggling to cope with increased numbers (Thompson 2007). The extent of such intervention is illustrated by the rising trend of caesarean section birth in Ireland (24.2% of total live births in 2003, 28.9% in 2012) (ESRI 2013). These figures represent an increase of 19.4% in the proportion of caesarean section births over the decade 2003 – 2012 and correspond with a fall in spontaneous births from 61.2% in 2003 to 55.6% in 2012 (ESRI 2013). Over 15% (15.5) of total live births in 2012 were assisted, using forceps/vacuum. The rising trend in CS rates started 20 years ago, when the 1993 rate of 13% rose to 20.5% by 1999, a 57% increase in the space of 7 years (Brick & Layte 2011). Although the rising age of mothers, and increases in preterm labour and other clinical risk factors account for some of this increase, these authors' analysis has shown that over half the increase in the caesarean section rate is due to a change in physician behaviour (Brick & Layte 2011). Previous generations were told hospital

birth was 'safer' (Murphy-Lawless 1998) and women did not realise the negative consequences of moving birth predominantly into hospital, such as the influence of the economic and industrialised models on childbirth.

Safety in birth is a vague and poorly defined concept (Devane & Begley 2004), frequently juxtaposed with risk to form a powerful narrative to support and justify the ongoing medicalisation of birth within a hospital setting. Intertwined with the constructions of risk is the normal/abnormal divide of birth discussed in the previous chapter of this thesis, which deems birth to have the potential to be abnormal until proven to be otherwise. These arguments sustain the dominant place medicine holds in the current maternity services and consequently the perpetuation of the medical model, with its focus on fixing the problems associated with birth. However, a counter discourse exists, which brings into sharp relief the limitations of the current organisation of maternity services in Ireland and challenges the established forms of authoritative knowledge. Women and midwives (especially self-employed community midwives) who support birth as a normal event hold an alternative understanding of birth, which preferences embodied ways of knowing and constructs the female body as a 'knowing' body rather than a site of unpredictable disaster requiring routine medical management (Chadwick & Foster 2014). An exploration of the dominant and subjugated discourses and their influence on the place of birth will demonstrate the social structures and different ideologies that interface at the time of in-labour transfer to hospital.

4.2 Authoritative Knowledge

Improved mortality and morbidity rates, which occurred at the same time as the relocation of birth to hospitals, have legitimised the knowledge of obstetricians and their involvement in birth, even when the improvements were mainly as a result of changes in the standards of living or improved public health (Symonds & Hunt 1996). Consequently, women and some midwives have been enculturated into accepting the benefits of medical proficiency and its underpinning hegemonic ideology in pregnancy and childbirth (Maher 2003). This preferencing of medical knowledge gives even further credence to obstetricians as the experts and supports their

ongoing position of influence (and power) within all aspects of childbirth (this is of specific significance to Ireland). This position reflects a Foucauldian reading of knowledge and power.

The 20th century social philosopher Michel Foucault in his history of medicine (*The Birth of the Clinic*) proposed that knowledge and power are in fact synonymous (Foucault 1973). His thesis is that there is an inextricable link between power and knowledge, each enabling the other (Foucault 1998). Power can only be exercised through the production of knowledge explaining that –

“there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations”

(Foucault 1977, p. 27).

Foucault does concede that several discourses may co-exist producing –

“different truths and different ways of speaking the truth”

(Foucault 1980, p. 51).

These truths are not always viewed on equal terms/as having equal power, some having a higher value than others, some truths are “subjugated, blocked and silenced” by systems of power (Foucault 1980). The dominant discourse may give the impression of speaking the truth, whilst subjugated discourses create a [sometimes] contradictory version of the truth or, rather, their own truth. This gives rise to an unequal power dynamic and interactions that are based on hidden struggles for power and claims for truth.

The effects of the power/knowledge nexus on contemporary childbirth settings are explored by anthropologist Brigitte Jordan in her writings on ‘authoritative knowledge’ (Jordan 1993). While several ideologies may exist within any sphere, Jordan, (in keeping with Foucault’s thesis on dominant and subjugated discourses) suggests that one will always emerge as dominant, assume the mantle of ‘authoritative knowledge’ and so gain authority over others (Jordan 1993). Authoritative knowledge is often associated with a perceived “*stronger power base*” (Jordan 1993, p. 56)

(e.g. the esteemed scientific knowledge of the man-midwives). This often leads to a devaluing of the other/alternative knowledge system – in the case of childbirth the knowledge of women and/or of midwives (Oakley 1981, Katz Rothman 1991). Thus, as shown in the previous chapter, the man-midwife (and subsequently the obstetrician) established himself as *the* expert, *the* holder of all knowledge, *the* practitioner who could ‘fix’ the doctor-described problems of childbirth. Obstetricians continue to make this argument as their unique selling point and thus maintain their dominant place within the cultural reading of birth (Langton 1994, Haertsh et al 1998, Gau et al 2002). The man-midwife introduced the notion that women’s bodies were inadequate and therefore required the skills of surveillance and intervention to function correctly, skills they had the knowledge and expertise to provide. The modern day obstetrician advances this theme within the context of the risk discourse of postmodernity by making claims of an ability to minimise risk and provide the safest options for birth in the safest place.

4.3 The Pursuit of Safety

Following the Enlightenment, and with modernity came a new way of viewing the world, its contingencies and uncertainties (Lupton 2013). Unanticipated outcomes were associated with human action rather than as the result of God’s will or nature, as was previously thought. In conjunction with the expansion of science, risk was increasingly viewed as something that was within the capacity of people to control via expert knowledge (Lupton 1999). The medicalisation of birth is a clear example that was underpinned by this new conceptualisation of risk.

As noted in the previous chapter of this thesis the debate surrounding who attended childbirth, in what place and in what manner is not a recent or new one; supporters of either side of the motion claim safety, e.g. - ‘*birth at home is safer*’, ‘*birth in hospital is safer*’, with views supported by opinion, anecdote and science (de Vries et al 2013). Riebel (2004) notes that -

‘it is often in the semantics of safety that midwives and obstetricians hold disparate views’ (p. 333).

A significant characteristic of these debates is based not only on risk and safety, but on the manner in which the evidence informing these views is interpreted and adopted (Coxon et al 2012). Different people construct their understanding of risk in different ways and, as a result, respond to risk in a different manner (Lupton 2013). This has had major consequences for the choices that are available to pregnant women (Reiger 2006) and the manner in which those of differing persuasions relate to the other.

4.4 Pregnant Women, Place of Birth and Risk

Higgs (1998) suggests that a key characteristic of the 20th and 21st centuries is the overwhelming identification of risks, with experts taking a central role in creating, identifying and managing them (Scamell & Alaszewski 2012). Risk theorists coin this era a 'risk society' (Beck 1992) defined by increasing and pervasive risks. The notion of increasing risks has been accompanied by attempts to reduce them (Lankshear et al 2005). This endeavour is especially evident in current maternity care where a "risk epidemiology" (Lupton & Tulloch 2002) has taken over the discourse around birth and the individualisation of risk is used to justify technological interventions during birth (Lane 1995). An opposing view comes from the ideology of salutogenesis which holds that the majority of women and babies are healthy in pregnancy, therefore maternity care should focus on maintaining their health (Downe 2010). Applying salutogenesis theory to maternity services and maternity care could lend itself to reconstructing the current dominant discourse of surveillance and risk aversion (Downe & McCourt 2008).

The concept of risk has come to define women's experiences (de Vries et al 2013) and while childbirth is deemed to be 'safer' than it has ever been in Western countries (in terms of mortality) the risk discourse has intensified (Lankshear et al 2005), possibly because of the belief that highly medicalised care is the reason that birth has become 'safer'. A practical example is offered by Smith et al (2012) - a discussion in relation to risk is initiated at the first point of contact between a pregnant women and a health care professional at the 'booking visit' (with a doctor or a midwife) where *low risk* or *high risk* status is allocated by the clinician to the woman and

her pregnancy. For a woman planning a home birth in Ireland justifying your low risk status is vital early in pregnancy in an attempt to meet the Risk Assessment of the MOU and be deemed 'suitable' within the guidelines of the HSE, in order to be 'allowed' to have a home birth.

In most countries of the Western world childbirth has been redefined as a medical event with obstetricians promising to predict, and then to minimise, the risks identified (Chadwick & Foster 2014). Through the realist, techno-scientific lens, in order to minimise risk, birth must be managed by experts, monitored continuously and be subjected to investigations to detect and define normality in the context of probing for abnormality. Measurement and surveillance are identified as techniques of power by Foucault (1973), as what was first couched as a choice (the opportunity to have pregnancy monitoring) soon becomes the accepted standard of care (McKinlay 1981), with women's compliance expected within the model of 'expertise' (Kirkham & Stapleton 2004). This risk context demonstrates clearly the relationships between normative discourse and power relations. The decisions women *should* make to reduce risk (in the view of those in power) have been dictated by science and obstetric medicine. It is not just obstetricians who espouse this ideology (Hollins-Martin & Bull 2005). Midwives (some) or, more specifically, midwives who practise within fragmented models of maternity care are held to have been compliant in the process of routinely medicalising birth and endorse a model of care that reinforces a medicalised conceptualisation of risk (Hunt & Symonds 1995, Edwards and Murphy-Lawless 2006). While midwifery is underpinned by a philosophy of normal birth, Parsons and Griffiths (2007) propose that some midwives acquiesce to the medical model because it is easier for them to comply with hospital norms²⁷) or because they have become enculturated within their location. Marsden Wagner explains this phenomenon in obstetricians and midwives with the phrase "*fish can't see water*" (Wagner 2001).

Midwives who support birth outside of a hospital (or indeed midwives in hospital settings who support normality in childbirth) contest the rhetoric of

²⁷ As noted in the section – 3.3.2 'The Invisibility of Midwifery in Ireland'

birth as routinely problematic and risky, and critique the high level of intervention in birth in contemporary maternity care. Drawing from research that has shown comparable outcomes in hospital and home settings (Wiegers et al 1996, Janssen et al 2009, Brocklehurst et al 2011) birth can be seen as normal and straightforward for most women. The already complex issue of risk in relation to birth is made more complicated by professional groups (and women) interpreting risk in different ways (Lindsey 2006).

Birth may be constructed as safe or as potentially risky for women and babies, and choice in relation to place of birth is influenced by one's perspective on the issue (Coxon et al 2013). For women who choose a hospital birth, the expert obstetricians and their technologies and interventions are viewed as a means of reducing risk and guaranteeing a safe birth (Davis-Floyd 1994). However as Beck and Giddens (Giddens 1998, Beck 1999) note, these guarantees have not always delivered on their promises and in fact in some cases (e.g. routine intervention) have been seen to do more harm than good in relation to maternal wellbeing in terms of morbidity and psychological wellbeing. This is explained more bluntly by Jo Murphy-Lawless –

“the assertion of obstetrics that it has conquered death making childbirth safe for women requires careful examination because the medicalisation of birth has not been an unqualified success and has not given to women all the benefits it claims to have done”

Murphy-Lawless (1998 p. 13).

Women (and midwives) who choose a model of care outside the culturally-held norm of hospital construct alternative definitions of risk in relation to childbirth (Viisainen 2001, Edwards and Murphy-Lawless 2006, Lindgren et al 2008a). Decisions women make in relation to place of birth are taken under circumstances that acknowledge and accept uncertainty, in that the outcome cannot be known (Coxon et al 2013). The socio-cultural theories of risk illustrate the impact that discourses of risk can have on any decision. Drawing from Beck's theory of a 'risk society' (Beck 1992), women who choose to birth at home would seem to be more concerned about the risks that medicalisation has imposed on normal birth. In addition, they may see

hospital medical technology as a threat that may reduce the embodied knowledge of their own abilities.

Iatrogenic risks arising from routine intervention in birth (e.g., need for medical pain relief due to use of oxytocin infusion), and the over-use of technologies (e.g., electronic fetal monitoring), structural conditions (e.g., over-crowded labour wards), and care offered by strangers, all contribute to this counter-discourse that is often mooted in the context of routine care of the hegemonic model (Lindgren et al 2008a, Seibold et al 2010). Lane (1995) states that risk in childbirth is a more complex matter than that offered by the *risky body* mantra, which does not account for the social context of pregnancy and birth. Managing risk must include managing social constructions; Lane (2012) suggests that this can only be done through relationships of trust, respect and continuity of carer. Women and midwives have made attempts to re-conceptualise birth “from high risk to low risk, at least for most low risk women” (Reiger 2006 p. 337), a position that has been supported by scientific fact (Department of Health, UK 1993, Guilliland & Pairman 1994, Begley et al 2009).

Whilst obstetric power in Ireland has, for the most part, remained unchallenged, there have been some attempts to provide a counter-discourse to the obstetric model, which is underpinned by the techno-scientific approach to risk. The next section will explore some of these changes in opinion and will provide an important insight into the culture and context of this study.

4.5 Place of Birth in Ireland in the Late 20th Century

The cultural critique of birth in Ireland (Section 3.3) explored the demise of home birth and the rise of obstetric-led care in Ireland; this section will examine the attempts to re-frame birth in the late 20th century and the impact that this had on the cultural milieu of birth.

Since 1991 all women in Ireland are entitled to access free maternity care under the Mother and Infant Care Scheme (MICS) (Department of Health and Children). The scheme supports hospital “inpatient and outpatient” care

(under the direction of a consultant obstetrician) and from a GP until 6 weeks after the birth of the baby. Although their contribution to the MICS is not readily apparent, midwives are employed within these units, for the most part, to support the obstetric-led service.

Care within the maternity hospitals/units is organised in a manner that has been described elsewhere as fragmented and provided by multiple caregivers (Murphy-Lawless 2011). Whilst doctors move throughout the hospital setting ('meeting' women during their antenatal, labour and postnatal experiences), midwives generally are based in one core clinical area (O'Connell 2011). Some level of continuity of carer may be experienced by women attending a midwives' clinic or availing of an 'early discharge home' or DOMINO option offered by some of the maternity hospitals. For the majority of women, continuity of midwife is not a realistic option in the current maternity services.

Devane et al (2007) suggest that change in the organisation of the maternity services in Ireland can be attributed to the activism of a few women, midwives, sociologists and health service managers. In 1996 a conference in Dublin "*Mother and Child 2000*" gave childbirth groups and academics an opportunity to present the most current evidence on place of birth and models of maternity care. The papers that emerged from the conference, known collectively as '*Returning Birth to Women*', highlighted an overarching theme, which called for change in the provision of maternity care. It was proposed that by the year 2000 women-centred care with a focus on the needs of women and of midwives should be a reality (Kennedy & Murphy-Lawless 1998). During the conference it was highlighted that a review of the Mother and Infant Care Scheme (MICS), completed in 1994 by the Mother and Infant Care Scheme Group (established by the Department of Health) had not been published. It was also noted that findings of a study on home birth, commissioned by the Department of Health and conducted by Marie O'Connor²⁸ (sociologist) in 1992 were not made public. "*The Report of the Maternity and Infant Care Scheme*" (1994) was finally published in 1997 (Department of Health and Children 1997).

²⁸ Marie O'Connor published the findings of the study in her book – *Birth Tides* (O'Connor 1995)

Devane (2011) notes that “*The Report of the Maternity and Infant Care Scheme*” did little to challenge the dominant model of hospital-based, obstetric-led care ignoring, as it did, the evidence to support other models of maternity care. However, in relation to home birth the review board acknowledged the difficulties health boards may face when attempting to arrange a home birth for women in a country with an undeveloped community midwifery services. It was deemed unacceptable for women to be placed in a position where they felt that they had no choice but to free birth – to birth at home without the support of any health care professional.

“The review group recognises the dilemma which confronts the Department of Health and the Health Boards at present in such cases. However, it is unacceptable that a woman should feel compelled to give birth alone or unassisted by a health professional or assisted by an unregistered person”

(Report of the Maternity and Infant Care Scheme Review 1994, DoH 1997, p. 23).

The review group recommended that pilot DOMINO and home birth schemes should be established –

“... to cater for women who cannot be persuaded to deliver in or at a maternity hospital / unit”

(Report of the Maternity and Infant Care Scheme Review 1994, DoH 1997, p. 63 – 64.).

This initiated a response by the Department of Health and Children to fund three pilot domiciliary birth projects (Devane et al 2007). An integrated home birth scheme (provided by a team of midwives who were employed by the regional hospital) was set up in Galway, a combined home birth and DOMINO scheme was established in a Dublin maternity hospital (again care provided by midwives who were employed by the hospital) and an integrated hospital and community team was established in Cork, where care was offered by Independent Midwives who were contracted to facilitate home births (Domiciliary Birth Group 2004). An independent review of these ‘piloted’ schemes recommended that models of integrated hospital and community maternity services should be developed nationally (Brenner 2003). To date there has been no clear, coherent integrated response from the government or the HSE (Domiciliary Birth Group 2004)

to action the recommendations from this report. Unfortunately the home birth scheme in Galway ended when its budget was redirected to fill a new neonatologist post within the hospital (Siggins 2003), in spite of local and national political lobbying by local women (Horan 2007).

Alongside the establishment and evaluation of these pilot schemes, developments in the Dublin North East Area²⁹ of the HSE led to the setting up of two Midwife-Led Units (MLUs) in Cavan and Drogheda (Devane et al 2007). In 1998 the then North Eastern Health Board (NEHB) commissioned a review group (The Condon Group) to consider the maternity services in that area, where rationalisation was proposed (Begley et al 2009). The report – The Condon Report -maintained the position that hospital-based obstetric care was the only tenable option (Condon 2000). The recommendations of the report suggested that 2 maternity units be closed because the number of women accessing their services was – “... *insufficient to provide consultants with sufficient experience to maintain their skills*” (Condon 2000 p. iv). These recommendations mirror government policy of previous decades, promoting the centralisation of maternity services.

Devane et al (2007) clearly highlight the inadequacies of the Condon report and in particular critique the groups’ review [or lack thereof] of international evidence. The NEHB rejected the recommendations of the report and this, coupled with ongoing public outcry generated by the closure of smaller maternity units in the area, led the health board to call for a new committee to review services - The Kinder Group (Devane 2011). The report published by this group – The Kinder Report - recommended the development of a quality maternity service, with a focus on women-centred care that was considered to be both safe and accessible (Kinder 2001). This report led to the development of a maternity services task force that resulted in the commissioning of two MLUs (Devane et al 2007). Even with the recommendations of The Kinder Report, establishing two midwifery-led units was only done in the context of a RCT because the HSE and Stakeholders (obstetrician, paediatricians, GP’s) wanted evidence generated

²⁹ Known previously as the North Eastern Health Board (NEHB)

within an Irish context to show whether midwife-led care was as *safe* as consultant-led care before the service would be established outside the trial and pilot status (Begley et al 2009). The MidU Study demonstrated that midwife-led care in the context of the two MLUs is indeed as safe as consultant-led care, results in less intervention, is evaluated by women with greater satisfaction and is cost effective (Begley et al 2009, 2011). In spite of the findings of the MidU study plans for the establishment of MLUs on a national basis have not emerged.

It must be recognised that the establishment of the pilot schemes and the MLUs represented a significant development in maternity care and provided options for some women in Ireland. However, an entrenched commitment to a policy of obstetric-led hospital-based maternity care remains. The provision of maternity services remained underpinned by a “*sense of confusion about the issues of safety and choice*” (Devane 2011, p. 14). Such difficulties are clearly illustrated in the unanimous ruling of the Supreme Court that **the State’s obligation to provide maternity care is fulfilled if maternity services are offered within the confines of a hospital [O’Brien Vs South Western Health Board 2003]**. It would appear that all women in Ireland have access to publically funded maternity services however, this does not constitute a choice in relation to place of birth, just access to care wherever the State deems to be ‘appropriate’ (Carolan 2003).

In February 2003 the National Expert Group on Domiciliary Births was convened to develop a national policy on domiciliary care. The report of this group (never published in a formal manner but available via - <http://www.lenus.ie/hse/bitstream/10147/44701/1/6287.pdf>) recommended that a more even distribution of domiciliary schemes and home birth provision was needed around the country and that an implementation group be established to facilitate this (National Group on Domiciliary Births 2004). The ‘new’ Domiciliary Births Implementation Group, did not meet until 2007 when it was convened by the HSE to deal with the acute ‘problems’ caused by professional indemnity insurance (OBoyle 2009). Prior to 2007, midwives working in a self-employed capacity offering a home birth service to women secured their professional clinical

indemnification via the Irish Nurses and Midwives Organisation (INMO); however, in 2007 this was no longer considered a tenable option by the INMO (Murphy-Lawless 2012). The immediate task of the Domiciliary Births Implementation Group was to ensure a mechanism for the indemnification of SECMs (OBoyle 2009). This was achieved via the States Claims Agency Clinical Indemnity Scheme and is facilitated if SECMs sign an individual Memorandum of Understanding (MOU) with their relevant HSE and practise within the confines of normality prescribed therein. Drafted in haste, this was not without controversy (OBoyle 2013). The MOU is a document that defines the scope of practice of the midwife (Millar 2009). It is more restrictive than the ICM definition of a midwife, EU regulations, or Scope of Midwifery Practice as defined by An Bord Altranais (An Bord Altranais 2010). The MOU has been described as having “*stringent terms of reference*” (Symon 2011 p. 193) and having criteria that prevent some women from availing of a home birth who would not be excluded in other jurisdictions (Millar et al 2008). OBoyle (2013) proposes that the ‘guidelines’ of the MOU are not guidelines but “*structural requisites for statutory indemnification*” (p.989) thus highlighting a home birth service determined by indemnity. The most recent Nurses and Midwives Act (Government of Ireland 2011)³⁰ calls for “adequate clinical indemnity insurance” for all midwives providing community care in a self-employed capacity. Within the terms of the Act, midwives risk prosecution (and criminalisation) if they fail to practise within the terms of the MOU, and offer care to women who do not meet the criteria. It has been argued that if circumstances change in pregnancy or labour that require transfer to hospital and where the woman declines to transfer, the midwife may then be forced to abandon the woman or to operate outside the MOU, without insurance, and thus to act illegally (Murphy-Lawless 2012). OBoyle’s work (OBoyle 2013)³¹ identifies the challenges this presents for SECMs and the potential impact on women’s agency and midwives’ autonomy.

³⁰ Signed into legislation on 21st December 2011

³¹ OBoyle’s paper (OBoyle 2013) – “Just waiting to be hauled over the coals”: Home birth midwifery in Ireland highlights the challenges autonomous midwives face in a maternity service underpinned by clinical indemnification and risk averse protocols

On the 25th November 2013 the Community Midwives Team of the National Maternity Hospital, Dublin facilitated a symposium “*Home Birth Back to the Future*” to discuss the future of home birth in Ireland. This meeting was timely given the issues raised by related High Court judgements earlier in 2013. The recurring theme of the day was ‘choice’, choice or rather the lack of choice and lack of options in relation to the maternity services and the models of care they can access. The difficulties not only for women but also for SECMs were raised (Dixon 2013) and reiterated the barriers met by midwifery practice at the fringes that OBoyle’s ethnography describes so clearly (OBoyle 2009).

4.6 Summary

Managing risk is not the same as facilitating safety (Dahlen 2014). This chapter has highlighted the ‘risk’ and ‘salutogenic’ discourses of the contemporary maternity services with specific reference to assumptions about birth that are culturally ingrained and impact on the way birth is viewed and organised. Authoritative knowledge and the concepts of risk were explored in order to highlight the narratives of birth that are relevant to (and dominant in) contemporary Irish society. The way these concepts inform the place of birth was outlined and discussed. These first four chapters have set the scene and provided the rationale for my research. In the next chapter, I identify the ethnographic framework that informs this study, and explore the epistemological and ontological perspectives that underpin the research design.

Chapter Five: Research Design – Philosophical, Theoretical and Methodological Underpinnings

5.1 Introduction

Walsh and Evans (2014) note the huge quantity of midwifery research that has emerged over the past 20 years and comment on its dissemination in an array of journals. However, they draw attention to the absence (in midwifery journals) of discussion and debate about the philosophical underpinnings of studies as well as questions of ontology and epistemology. The importance of clarifying the philosophical, theoretical and methodological underpinnings informing the conduct of a research study is highlighted by Denzin and Lincoln (2011) and Creswell (2012). They place emphasis on evaluating the congruence of these underpinnings with the researcher's own philosophical perspective in order to make explicit the assumptions on which a study is based.

In this chapter I will identify the ethnographic framework that informs this study, this will include an exploration of the epistemological and ontological perspectives that underpin the research design. I will highlight the appropriateness of this research design (critical ethnography) in the context of this specific study and review the ways this informed the analysis of the data.

5.2 Ethnography – an Introduction

Chapters 3 and 4 explored the discourses that have influenced the culture of birth in Ireland, where certain understandings of birth, birth models and environments of care are given dominance over others. This research focuses on the meeting of these understandings of birth, and seeks to explore both the home and the hospital interface in maternity care as experienced during in-labour transfer to hospital during planned home birth. To elucidate this interface I needed to explore women's birth stories and the experiences of in-labour transfer to hospital; contextualising these experiences with reference to the historical, professional, political and cultural tensions that pervade birth in Ireland. Ethnography, with its

emphasis on culture and cultural phenomena, provided a framework to do this; it allowed me to make sense of the complexities of birth in Ireland by accounting for not only individual experiences of in-labour transfer but also the cultural influences that shape them. In this sense, this study is grounded in the participants' reality while recognising the interplay between social constructions and the specifics of real life.

With its roots in cultural anthropology, ethnography facilitates not only an understanding of experiences but also the social and cultural factors that contribute to them (Agar 1985). Skeggs (2001) suggests that ethnography takes into account "the multi-faceted ways in which subjects are produced through the historical categories and contexts in which they are placed and which they precariously inhabit" (Skeggs 2001, p.433). Ethnography is based on the premise that human actions and experiences are complex; are informed by social meanings, and are influenced by intentions, values, rules, beliefs and aspects of culture (O'Reilly 2009). The aim of ethnographic research is primarily to explore cultures, to describe what is happening in a specific setting and how people see their own actions and the actions of others, as well as to describe the context in which these actions take place (Hammersley & Atkinson 2007). This is achieved by producing descriptions, accounts and interpretations that are politically, historically and personally located (Tedlock 2000). This "thick description", to use the phrase coined by Geertz (1973), is obtained by drawing on multiple methods of data collection, which involve direct and sustained contact with people in the context of their daily lives (van Maanen 2011). While the term "direct and sustained contact" is somewhat ambiguous, most ethnographers agree that:

"the ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on the issues with which he/she is concerned"

(Hammersley & Atkinson 1989, p. 2).

Ethnography provided a practical framework to guide my entry to the research field and my exploration of the social, political and cultural context of the interface of home and hospital maternity care in Ireland.

Ethnography, like all research approaches, has evolved and developed over time (Crowley-Henry 2009). Of greatest relevance to this study is its movement from a descriptive and naturalistic methodology in the 19th century to the theoretically diverse ethnographies of the 20th century, which acknowledge the influence of the researcher and the research design on study findings. The origins of ethnography lie in the late 19th century, in anthropological investigations during ‘New World’ colonisation; these investigations aimed to study new and unfamiliar cultures (Savage 2006). These descriptions of non-Western, indigenous cultures became part of the records associated with exploring and travel (Rees & Gatenby 2014). Fieldwork was not, for the most part, carried out by the anthropologists; instead, data were gathered by civil servants, colonial police, missionaries and travellers (sometimes for a specific purpose – for example, a census) (Crowley-Henry 2009). This information was theorised and analysed by anthropologists, but the lack of context meant that cultural beliefs and practices were often made fit to existing theories rather than contribute to a new understanding (Alvesson & Sköldberg 2009). By the beginning of the 20th century these “armchair ethnographers” disappeared as a new era of social scientists sought to challenge the claims of positivism (Alvesson & Sköldberg 2009). These developments in ethnographic research happened alongside disillusionment with the positivist claims that the social world, like the physical world, is predictable and based on the laws of causation (Moses & Knutsen 2012). Interpretivism, which holds that the world is known through an individual’s interpretation of it (Oakley 2000), challenged the concept of an objective truth (Moses & Knutsen 2012). The ethnographers of the 20th century believed that truth was not absolute but relative, influenced by time, place, interests and purpose (LeCompte & Schensul 2010). One of the most notable ethnographers of the early 20th century was Bronislaw Malinowski, a social anthropologist; drawing on interpretivism, he sought to describe culture through the eyes of its participants. Malinowski’s ‘immersion approach’ set a template for

ethnographic methods, providing a model of participant observation for the generations of ethnographic researchers that followed (Moses & Knutsen 2012). The ethnographic methods of Malinowski involved in-depth fieldwork, with researchers living among and observing a particular group of people (typically non-Western societies and cultures) for prolonged lengths of time. The 1960s heralded a move from the ethnographies of non-Western cultures to geographical locations in closer proximity to the homes of the researchers and their university departments (Scott Jones 2010). Influenced by the Chicago School (the Department of Sociology at the University of Chicago, which gained prominence in the 1920s and 1930s), ethnographic researchers were encouraged to engage with discrete subcultures within their own societal locations (Crowley-Henry 2009). These subcultures were most often those deemed to be on the margins of society (e.g. immigrants, street gangs, gay men, prostitutes). In a similar manner to classic ethnographies, these urban/at-home micro ethnographies demanded lengthy periods of participant observation (Thomas 1993). While the researcher valued the experiential knowledge gained through participation in the research field, these ethnographies were criticised for their quasi-positivist position, which sought the ‘facts’ about cultures, described solely from the researcher’s perspective (O’Reilly 2009). Claiming an authoritative and unbiased account of the cultures they studied, the researchers (usually white middle-class male academics) did not consider how issues such as gender, race, class and power shaped their view of the world or informed their interpretations (Savage 2006). By the end of the 20th century, ethnography in its naturalist approach of assuming the objectivity of the researcher was contested. Ethnographers could no longer ignore their influence on the research process (van Maanen 2011). Emerson et al (1995) suggest that no ethnographic researcher can be a detached observer since their perspective is intertwined with the phenomena observed. In contemporary ethnographic studies, researchers consider and reflect on the role they play in influencing the research; reflexivity is regarded as an essential part of the research process (Crowley-Henry 2009).

I will outline how ethnography shaped this study and guided it toward a critical ethnography later in this chapter (Section 5.4). However, classic

ethnographies have been criticised in relation to their claims of objectivity and assumptions that the researcher can maintain objectivity when observing another culture (Hammersley & Atkinson 2007). These criticisms have influenced contemporary ethnographic research in that the researcher and their background, experiences, beliefs and reasons for undertaking a study are no longer ignored or considered irrelevant (Scott Jones 2010). Instead they are considered to be an integral part of the research process and therefore should be explored. In Chapter 2, I highlighted what led me to this study both on a personal and a professional basis. I will now consider my philosophical stance and why I decided that this methodology (ethnography) would best inform my understanding of knowledge (epistemology) in order to make sense of how I perceive reality (ontology).

5.3 My Epistemological and Ontological Position

Epistemology is a branch of philosophy concerned with the nature of knowledge and so gives a “certain understanding of what it means to know” (Crotty 1998, p.10). I believe that knowledge is created by culture and social processes. Individuals are historically and socially constituted (Crotty 1998) and therefore explorations of experiences must be context-specific and historically located. In previous chapters of this thesis, I identified the historical, social, cultural and political influences on birth and the impact that they have on the understandings of birth and the organisation of maternity services. The understanding by women, midwives and obstetricians of birth and place of birth is influenced by social and cultural conditions and by historical events. Therefore, their experiences of in-labour transfer are constructed within the cultural understandings of birth in Ireland.

This epistemological perspective is in keeping with the philosophical stance of social constructionism, which assumes that truth cannot be objective but rather meaning and knowledge is constructed (Crotty 1998). The seminal writings of Berger and Luckmann in *The Social Construction of Reality* suggest that the epistemology of constructionism is ultimately founded on the understanding that meaning and knowledge are not created in a vacuum but are constructed relative to social contexts (Berger & Luckmann 1966).

Crotty (1998) defines constructionism as follows: “all knowledge and therefore all meaningful reality, as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context” (Crotty 1998, p.42). Epistemologically, the knowledge claims of ethnography are in keeping with the fundamental assumptions of social constructionism in that ethnography focuses on understanding the experiences and behaviours of people who live and interact within a social group.

While individuals are born into a world of meaning that reflects the culture and values of the society in which they live, all knowledge depends on how we create an understanding of our interactions with each other and this world/society (Crotty 1998). This understanding may be constructed in different ways as an ongoing process through personal, narrative and culturally accessible resources (Silverman 2010). Schwandt (2003) suggests that groups and individuals may have unique perceptions of reality. Therefore constructionists believe that objective reality does not exist in that there are no fixed truths, but rather multiple perspectives of reality that are socially, politically, culturally and economically influenced (Greten 2009). Reality is produced and reproduced; there are multiple constructions (Maxwell 2012); therefore constructionists do not seek to produce ‘a reality’ but rather represent a number of perspectives all considered to be equally relevant (Hammersley 1992).

As the previous chapters have highlighted, diverse perceptions of birth exist, and these perceptions are played out in the views and opinions that women, midwives and obstetricians hold in relation to place of birth. Throughout this research, I tried, through my constructionist positioning, to remain mindful of the different ideologies at the interface between home and hospital birth; this is reflected in the inclusion of the different participant groups who have informed this study. It is also apparent in the framework of data analysis, in that the Voice-Centred Relational Method (VCRM) of data analysis focuses on “*keeping the respondents’ voices and perspectives alive*” (Mauthner & Doucet 1998, p. 119) and does not

preference one voice above another. The findings of this study present a workable mesh of all participants' experiences and highlight the similarities and differences across and within participant groups.

This representation of different, valid perceptions of reality reflects my ontological position. Crotty defines ontology as the branch of philosophy that deals with "*the nature of existence ... the structure of reality*" (Crotty 1998, p.10) and so gives an understanding of 'what is'. This thesis draws from Crotty's writings on ontology and locates its claim in relation to knowledge in a balance between the two perceptions of relativism and realism. Crotty (1998) suggests that social constructionism is epistemologically relativist and ontologically realist: realist in the sense that the world exists 'out there' and the way meaning is interpreted and socially constructed is real; relativist in that there is no absolute truth, but rather individuals perceive and interpret reality according to "*the sense we make of things*", influenced by historical and cultural factors (Crotty 1998, p.64). There is friction between these two philosophical stances if taken at their extremes; the divergences of the philosophies of epistemologically relativism and ontologically realism can be problematic in that claims of objective truth are made about the subjective experiences studied. Atkinson (1992) suggests that combining the principles of conventional realism (also referred to as naïve/strict realism within the literature) and the assumptions of ethnography presents something of a paradox for ethnographic researchers, given the intersubjectivity and shared experience of culture emphasised by ethnography. Therefore I adopt Hammersley's concept of 'subtle' realism (Hammersley 1992). Hammersley (1992) proposes 'subtle' rather than 'naïve/strict' realism for the contemporary ethnographer, in that this rejects "the notion that knowledge must be defined as beliefs whose validity is known with certainty" (Hammersley 1992, p.52). Rather, subtle realism assumes that we can only know reality from our own perspective of it; thus research does not aim to produce *the* reality but rather a *representation* of it. In this sense, subtle realism emphasises representation rather than reproduction of reality (Rolfe 2006). Any representation and claims in relation to reality that this study makes will thus be fluid and highly contextual. The findings are influenced by the constructions and

interpretations of the research participants, including that of the researcher. While interpretations of reality are constructed and can mean different things to different people, this does not imply that the constructions cannot represent social phenomena as per the claims of positivism that one true form of reality exists (Hammersley & Atkinson 2007).

The principles of a postmodern understanding of knowledge generation are interwoven in this study; there are multiple understandings of reality. I have thus incorporated research methods that support the exploration of these realities. The positions of postmodernism that challenge the notion of an objective truth, and claim that knowledge may differ for each individual, are compatible with my epistemological and ontological positions. However, while I acknowledge the subjective nature of the experiences of in-labour transfer, an uncritical acceptance of postmodernism and the assertion that any findings would be totally subjective could call into question the utility of this study. In order to overcome this criticism and avoid descending into absolute relativism, I suggest that the relationship between ontological subtle realism and epistemological relativism provides a balance for this ethnographic study, offering a philosophical underpinning that asserts that there is a social world independent of our knowledge of it and an epistemology that argues that it is knowable, while, as suggested by Davies (2008), the claims of how *much* we can know about that reality are not over-extended.

Hastrup (1995) argues that any construction of reality cannot be entirely subjective because understanding must be shared for it to contain meaning at all. With this in mind, an ethnographic framework helped me to reveal shared cultural expressions and variations across and within the participant groups and their significance for understanding the interface at in-labour transfer.

5.4 The Development of this Critical Ethnography

Section 5.2 provided an introduction to ethnography and highlighted its methodological appropriateness for this study and for my epistemological

and ontological perspective. I will now consider how this study moved toward a critical ethnography.

My immersion in the cultural context of birth (and specifically home birth) in Ireland has informed this study, not only in respect of the findings but also in the manner in which the methodology evolved. Situations of power and dominance, involving gender, professionalisation and the medicalisation of birth, have historically influenced the culture of birth (Murphy-Lawless 1998, Oakley 2000, Davis-Floyd 2003) (see Chapter 3). Issues of power and authoritative knowledge continue to play out in the current maternity services in Ireland, and were evident in the emerging data of this study. ^{Fieldnote 1} Ethnography provided a framework to describe the interface of home and hospital maternity care and the issues of power that were playing out in the data, but this study needed to go beyond a descriptive understanding to ensure that new knowledge of the experiences of in-labour transfer emerged. Purely to describe these experiences would maintain the *status quo* and risk locating the findings solely within historical explanations. I worried that this would produce a research endeavour with little relevance to the lives of women, midwives and obstetricians, and with little practical utility for the maternity services and the provision of obstetric and midwifery care. Rather than just explain observable experiences, this study also needed to critique the conditions that enabled these events. The theoretical orientation of this ethnography drew from the traditions of critical inquiry in that I sought to move beyond 'describing' the interface of in-labour transfer, and aimed to capture the issues in relation to ideology and power. I thus planned to move from description to a cultural critique, with acceptance of the obligation to present the findings to inform change (Thomas 1993).

Critical ethnography has links with critical social theory in that critical social theorists study the construction of knowledge and the organisation of power in society, exploring the relationships between power and culture (Kincheloe & McClaren 2005). The search for knowledge is considered emancipatory and is therefore used for the purpose of change (Crotty 1998).

Hammersley (1990) explores the application of critical inquiry to ethnographic study and notes:

“Conventional ethnography may be criticised for simply representing things as they are ... or ... representing them as they appear to the people being studied ... critical theory, by contrast, is concerned with dispelling ideology and thereby promoting emancipation.”

(Hammersley 1990, p. 13).

Watson (2012) suggests that critical ethnography links rich individual ethnographic accounts with layers of contexts and social structures, attempting to explain rather than just describing social phenomena. Particular attention is paid to questions of power in that critical ethnography seeks to understand the origins, mechanisms and processes of power that exist within a culture (Grbich 1999, 2007). Carspecken (1996) suggests that this focus on power is concerned with social inequalities and a desire to challenge the practices that sustain unequal power relations within a culture by moving the focus from ‘what is’ to ‘what could be’ (Carspecken 1996, Denzin 2001). This understanding of critical ethnography informs this study. It allowed me to consider the power imbalances, how they were maintained, and the consequences of the imbalances inherent in the experiences of in-labour transfer.

In my attempts to look deeper into the issues of power surrounding birth and place of birth, I used ethnography as my starting point. My discussion on power and knowledge laid out in Chapter 4 forms the theoretical basis from which the rest of this critical ethnography is built. In Chapter 4, Foucault’s notion of power was used to support the critique of the regimes of knowledge that historically have influenced the culture of birth and the organisation of maternity services in Ireland. I also drew on Foucault’s work to critique the interface of home and hospital birth. My rationale for including Foucault’s theoretical perspective lies in his conceptualisation of power and its connections to knowledge, surveillance and normativisation. Both Foucault’s fluid conception of power and his recognition of disciplinary power are of particular relevance to this study. Drawing on Foucault’s notion that power is a dynamic entity, Hutchinson et al (2006)

suggest that we (as individuals) are simultaneously undergoing and exercising power, rather than one person 'owning' it. Foucault claimed that power comes from everywhere (Foucault 1980), is 'web-like' rather than linear, and infiltrates everyday life, and also that there is an inextricable link between power and knowledge, each enabling the other (Foucault 1980). Several discourses may co-exist, producing "*different truths and different ways of speaking the truth*" (Foucault 1988, p. 51). These truths are not always viewed on equal terms or as having equal power, some having a higher value than others (Foucault 1980). The dominant discourse may give the impression of speaking the truth, whilst the non-dominant/subjugated discourses create a (sometimes) contradictory version of the truth. This gives rise to an unequal power dynamic and interactions that are based on hidden struggles for power and claims for truth. This aspect of Foucault's theorising is particularly useful when trying to understand the way in which power is embedded and intertwined within cultural systems, such as the maternity services, why some discourses gain ascendancy over others, and how this influences the experiences of in-labour transfer.

Given that critical ethnography is considered inherently political and transformative, using this methodology to underpin an exploration of the interface of home and hospital birth in Ireland made it possible to focus not only on the relations of power within the interactions but also on identifying the possibilities for transformation in these relationships. Hammersley and Atkinson (2007) highlight two key features of critical ethnography that differ from conventional ethnography:

- 1) the extent to which the political agenda influences the researcher
- 2) the extent to which the ethnography is used to influence political and emancipatory change

(Hammersley & Atkinson 2007, p.11).

At the conception of this study I did not have an assumption of how the interface of home and hospital maternity care needed to change; I wanted to understand it, so as to inform the provision of maternity care and areas for

further research, where appropriate. In Chapter 2 I provided an insight into my philosophy as a midwife and the importance I place on adapting and focusing maternity care to meet the needs of women. This is also reflected in the research I undertake, given that I strive to make a difference to women's lives by exploring their experiences to inform midwifery practice, midwifery education and the organisation of the maternity services. As my diary indicates, ^{Diary Entry 2} I did not consider my purpose and aims to be political; they are part of who I am as a midwife. I now realise that any intent to bring about social change is political and, therefore, by the nature of how I engage with midwifery I am political. While I suggest that this study was conceived to produce knowledge to inform change rather than to advance any personal agenda, I am aware that this statement is open to critique. I may not be able to dispel such criticism other than to make reference to Chapter 6, which demonstrates that this study remained committed to disciplined, rigorous and systematic research, and used such methods as Voice-Centred Relational Method (VCRM) to respect the voices of the study participants while acknowledging my personal reflections in relation to the study and the data. These reflections are offered throughout this thesis.

The extent to which ethnography is used to influence political and emancipatory change is also raised by Hammersley and Atkinson (2007). Foley and Valenzuela (2008) suggest that change associated with critical ethnography spans a continuum from political activity at one end to influencing policy change at the other. This study takes the latter position; this is explored in Chapter 9 of this thesis where I suggest that the findings of this thesis can inform the organisation of maternity care. In relation to the emancipator intent of critical ethnography highlighted by Hammersley and Atkinson (2007), the term emancipatory is not without its concerns and I am aware of the notion that emancipation may be viewed as oppressive by the participants of this study. I adopt Mary Stewart's view that critical ethnography can be viewed as a tool for emancipating discourses (Stewart 2008) and suggest that elucidating the experiences of in-labour transfer with the intent of giving them equal voice is in itself emancipatory. Chapter 9 explores the implications for change that I suggest emerge from this study

and the plans for ongoing negotiation with key stakeholders that is needed to support the development of the maternity services and the provision of care.

The initial stages of this study led me to ethnography, highlighting its appropriateness as a methodology and indeed a practical framework to guide this study. The broad principles of ethnography have been extremely useful (I will demonstrate in the next chapter how these informed the methods of the study and so the production of knowledge), but aligning this ethnography with a critical approach guided by discourses of power and knowledge has enabled me to identify the possibilities for transformation.

5.5 The Use of Reflexivity in This Critical Ethnography

In this chapter and earlier chapters, I have made several references to the criticism of naturalism and the unavoidable influence of the researcher on all aspects of the research process. In this study, I attempt to avoid the pitfalls of a naturalistic approach and of a failure to question one's own influences on the research process by the use of reflexivity. Reflexivity refers to the way a researcher:

“... understands how her social background influences and shapes her beliefs and how this self awareness pertains to what and how she observes, attributes meaning, interprets action and dialogues with her informants”.

(Wasserfall 1997, p.152).

This is achieved by “*turning back on ourselves the lens through which we are interpreting the world*” (Goodall 2000, p. 137) and so highlighting the impact of the researcher's socio-historical location on the research process. Hammersley (1992) cautions against the overuse of reflexivity, that leads to a “confessional mode” of ethnography. The reflexive accounts presented in this thesis aim to avoid both the confessional mode and the risks of the kind of “*interpretive omnipotence*” (van Maanen 2011) that places the researcher outside the events being described.

VCRM provided a practical framework to make explicit my process of reflexivity during analysis of the data. With the fourfold set of readings of

analysis, the researcher focuses on their response to the data; this requires the researcher to recognise how they are “*socially, emotionally and intellectually located*” in relation to the research participants (Mauthner & Doucet 1998, p. 127). In keeping with Carspecken’s (1996) approach to reflexive critical ethnography, I do not limit my use of reflexivity to the phase of data analysis; I also focus my exploration on the design of the study and fieldwork and the writing of this ethnography. VCRM also provided a useful framework to connect my philosophical and theoretical perspective with the methodology of this study.

5.6 Data Analysis - Connecting my Philosophical and Theoretical Perspective with the Methodology

Mauthner & Doucet (1998) suggest that data analysis within a qualitative study is:

“not a discrete phase of the research process confined to the moments when we analyse interview transcripts. Rather, it is an ongoing process which takes place throughout, and often extends beyond, the life of a research project”

(Mauthner & Doucet 1998, p. 126).

In this study I considered the activities of data collection and data analysis simultaneously. The questions I asked during interviews informed my observations and vice versa, questions generated during the fieldwork guided data collection during interviews. ^{Fieldnotes 3 & 4} The reflections I offer in relation to fieldwork highlight my insider/outsider position. “*Ethnographers are part of the social world they study*” but, as researchers, their analytical gaze must be maintained in order to “*develop the ability to stand back and reflect upon themselves and the activities of the world*” (Hunt & Symonds 1995, p. 40). As I explored ways in which I could make meaning of the data and maintain my analytical gaze, the complexity of this task became apparent. I wanted to represent the experiences of those centrally involved during the interface of home and hospital birth, drawing from their experiences and the cultural context in which they occurred. At the same time I was aware that my representation could be one of many interpretations; therefore the subjective nature of the analysis had to be explicit. The reflexivity this required meant that I needed to understand my

“*personal, political and intellectual autobiography*” (Mauthner & Doucet 1998, p.121) and establish where I was positioned in relation to what I heard at the interviews and what I saw at the observations. It was also necessary that I acknowledged the critical role I “*played in creating, interpreting and theorizing research data*” (Mauthner & Doucet 1998, p. 121). Analysis of these data required a balance between representing the experiences of the participants, my interpretation of what I heard and saw, and the conceptual framework through which I viewed the data. Luckily, reading the doctoral work of Nadine (Pilley) Edwards (*Women's experiences of planning a home birth in Scotland*, (Edwards 2001) brought me to VCRM, and a way in which I could maintain the voices of the participants of the study whilst acknowledging the cultural context and recognising my role in the research process. The framework also provided a way to connect my philosophical and theoretical perspective with the methodology and make explicit how this influenced my interpretations.

Based on the work of Lyn Brown and Carol Gilligan and developed by Natasha Mauthner and Andrea Doucet (Gilligan 1982, Brown & Gilligan 1992, Mauthner & Doucet 1998), VCRM focuses on exploring and understanding the participant's views of their:

“relationships to the people around them and their relationships to the broader social, structural and cultural contexts within which they live”.

(Mauthner & Doucet 1998, p. 125–126).

This method of data analysis is underpinned by relational ontology, which positions human beings in a complex web of intimate and larger social relations (Mauthner & Doucet 1998). Woodcock (2005) suggests that this relational construction of knowledge does not dismiss the epistemological stance of social constructionism, rather it adds the relational dynamics between humans that contribute to knowledge construction within a social and cultural context (Gergen & Gergen 2008). Carol Gilligan's original work on the VCRM (e.g. in the seminal text ‘In a different voice,’ Gilligan 1982) emerged during her extensive research with girls and women during which she sought spaces to hear female voices that were “traditionally silenced” (Gilligan 1982, Brown & Gilligan 1992). In later writings,

Gilligan suggests that the *different voice* is not always identified by gender rather she suggests that those who do not have a strong/loud voice may be linked by theme (Gilligan 2011). Given the dominant assumptions in relation to birth that have informed the organisation of the maternity services in Ireland (Chapter 3 and 4) the voices of those who support and choose birth at home could be viewed as the *different voice*. VCRM enabled me to hear the dominant and the different voices in relation to birth in Ireland and thus elucidate the interface of home and hospital birth. This was in keeping with Gilligan's view that highlights the:

"importance of everyone having a voice, being listened to carefully, and heard with respect"

(Gilligan 2011, p. 24).

VCRM calls for a 4-stage process of listening to and reading data (Mauthner & Doucet 1998). Each reading is guided by a different question in order to focus an understanding on individuals in their social contexts and the complexities of their relationships. Explicit within this framework is a need for the researcher to consider their own response to the narrative.

Reading 1: The story and who is speaking

- Reading and listening for the overall story or plot
- The second focus of this reading is to consider the researcher's response to the story and examine reflexively how this influences the interpretation of the data.

Reading 2: In what body? The voice of the 'I'

- The second reading focuses on the use of 'I', considering how the research participants talk about themselves and their experiences.

Reading 3: Telling what story about relationships?

- The third reading is concerned with relationships and how the participants speak of relationships with key people in their lives and how these relationships influence their experiences.

Reading 4: In which societal and cultural frameworks?

- The fourth reading places the participant's stories in the wider social, cultural and political contexts and social structures.

(Adapted from Mauthner & Doucet 1998).

In Chapter 6 (Section 6.8), I detail the practical application of the steps of VCRM to this ethnographic study.

5.7 Why Not a Feminist Ethnography?

Given the subject area of this research and my rationale for undertaking it, it was appropriate to explore the understanding that feminism could have added to this study. The feminist critiques of dominant discourses suggest that the voices of women and marginalised groups have been silenced (Gilligan 1987); one of the goals of feminist research is to rectify this. In Chapter 3 of this thesis I explored the predominance of obstetric (traditionally male) knowledge and the impact that this has on choices available to women, the role of the midwife (traditionally female) and the medicalisation of birth in the Western world. In this exploration I made reference to the feminist critiques of birth and models of maternity care in the 21st century (e.g. Donnison 1977, Murphy-Lawless 1998, Oakley 2000, Davis-Floyd 2003, Edwards 2005). These critiques have held gender issues of male dominance to be accountable for a maternity service that supports obstetric-led, hospital-based care in the main, a service that has controlled childbirth with little regard to women's experiences (Murphy-Lawless 1998). In the case of this study, a feminist ethnography could provide an appropriate framework to explore the influence of gender in the current maternity services. However, Annadale and Clarke (1996) caution against such gender essentialism and suggest that explaining the oppression of women (within the maternity services) as a consequence solely of patriarchy puts limits on the new knowledge that could emerge. This gender essentialism does not account for the contribution that midwives (traditionally female) have made (and continue to make) to the culture of birth. To suggest that all midwives in Ireland embrace the philosophy of normal birth is misleading. Midwifery in Ireland and the identity of midwives are not fixed; as I will demonstrate in Chapter 8, they are subjects of contestation.

In Chapter 4 I critiqued the dominant assumptions that have informed the organisation of maternity care in Ireland and thus the choices available to

women. I acknowledged the very important influence that gender has had historically on the culture of birth in Ireland; however, the relationship of gender is not the primary focus of this study. The interest of this study lies in the interface of the ideologies of birth at the time of in-labour transfer.

5.8 Summary

A research design that reflexively incorporated the tensions of multiple truths and issues of power and subjectivity is essential to explore the complexities of the interface of home and hospital maternity care in Ireland. In this chapter I have explored the ethnographic framework underpinning the research design and examined my assumptions that underline the methodological choice.

The next chapter details how the philosophical and theoretical positions that influenced this research design are incorporated in the methods of this study.

(For Fieldnotes and Diary Entries please see Appendix 2, Pages 426 – 428)

Chapter Six: Research Methods

“Culture is generated by shared storytelling in which beliefs, identities and relationships are linked to the narrative, as well as actions and events”
(Ólafsdóttir & Kirkham 2009, p. 174).

6.1 Introduction

This chapter details the research methods used in this study. A retrospective, reflexive approach is used to explore the relationship between the research design discussed in the previous chapter and the research methods. The chapter highlights the methods adapted to gain access to the fields of home and hospital birth, the recruitment of participants, how I collected data and the phases of data analysis. I will demonstrate the dilemmas I encountered in the field and the manner in which I maintained ethical principles and trustworthiness in the conduct of the study.

6.2 A Multi-sited Ethnography – One Study, Two Fields

The opportunity to focus on the interface of home and hospital birth from the perspectives of those centrally involved, required an exploration of two inter-related fields: the field of home birth and the field of hospital birth. The fields were complex, constructed social entities, and I will offer some detail in relation to these settings in Sections 6.6 and 6.7 of this chapter. This description will provide enough information to give a picture of the locations without disclosing details that could make the sites or the participants identifiable.

The fieldwork for this study involved a multi-sited approach. Robben (2007) suggests that multi-sited fieldwork is not the same as fieldwork in multiple sites. The latter relates to replicating the same study in multiple places (Robben 2007), whereas multi-sited fieldwork is based on:

“ ... chains, paths, threads, conjunctions, or juxtapositions of location in which the ethnographer establishes some form of literal, physical presence, with an explicit posited logic of association or connection among sites that in fact defines the argument of the ethnography”.

Marcus (1995, p.105).

In this study, these two meanings overlap; both approaches were used, when appropriate, to meet the needs of the study. This fluid understanding of a

multi-sited ethnography allowed me to carry out fieldwork in and across the sites of home birth and hospital birth, and to follow in-labour transfer from home to hospital physically, and also through the levels of HSE policy and jurisdiction. Following the paths or threads of in-labour transfer led me to other places; for example, to postnatal breastfeeding groups, the Home Birth Association, the Community Midwives Association, sites of midwifery education, and GPs. Data were collected at the micro-level, exploring the context and experiences of the interface of home and hospital birth, and also at the meso-level in so far as it was relevant to the participants of this study. Therefore, within this multi-sited ethnography, I explored “*down, up, sideways, through, backwards, forwards, away and at home*” (to use the apt words of Hannerz 2006, p.23) and travelled distances that ranged from 5kms to 250kms.

6.3 An Ethnographic Approach – from Methodology to Methods

Ethnography has been described as eclectic in its use of multiple methods of data collection (O’Reilly 2009). Observation, interviews, and reviews of relevant documentation and artefacts may guide a particular study, depending on its needs (Hammersley & Atkinson 2007). The choice of methods used in this study was influenced by the critical ethnographic methodology discussed in the previous chapter. They were chosen to explore the cultural, social and political context of in-labour transfer to hospital during planned home birth. The flexibility supported by an ethnographic research design allowed me to use a combination of research techniques and engage reflexively with observations and in-depth interviews. This flexibility also made it possible to widen the scope of the fieldwork to include the observation of labour at home, and home birth/in-labour transfer (Section 6.6.1). I regard the ongoing process of developing and expanding the research methods as a strength of this study, in that I responded to issues as they emerged in the field.

The two main sources of data collection used in this study were participant observation and in-depth interviews. Occasionally other sources contributed to uncovering issues relating to the interface of home and hospital birth (e.g. relevant legislation, media reports, any public communications of healthcare

providers, Health Service Executive (HSE) publications). I have highlighted in the text of this thesis when this was the case.

6.3.1 Observation

Observation of research participants in their natural environment has become synonymous with ethnography (Forsey 2010). For this study I conducted over 220 hours of participant observation. I observed:

- antenatal discussions between women planning a home birth and the SECM offering them care (the ‘antenatal visit’) (n= 32 episodes with 23 women)
- women labouring and birthing at home supported by an SECM (n=8)
- women labouring at home (supported by a SECM) and transferring to hospital during their labour (n=2)
- one-woman transfer to hospital directly after the birth of her baby

Observations in ethnographic studies enable the researcher to place what is seen in the context of the cultural background against which those observations occur (Baszanger & Dodier 1997). Being in the field provided a valuable means of observing interpersonal dynamics; I gained a deeper understanding of the complexities of home birth and of the interface of home and hospital birth. These observations revealed the intricacies of the socio-cultural dynamics and some of the culturally learnt behaviours inherent in the interface of home and hospital birth. Some of these were not mentioned by the participants during the interviews; this highlighted a tension between what the participants did and what they recalled as their experiences. Exploring what people ‘do’ as well as what they ‘believe’ is fundamental to ethnography (Brink & Edgecombe 2003). This does not mean that one account should gain precedence over the other, but it does reiterate the point made in the previous chapter – that multiple understandings of reality may co-exist.

The lengthy immersion in the field that is a characteristic of conventional ethnography was adapted and a more pragmatic version of observation was undertaken – pragmatic in that I focused the observations on times in

women's lives that were relevant to this study. It was not, however, so pragmatic in the sense that an ethnographic study of any aspect of home birth in Ireland necessarily involves a dispersed population of midwives and of women (i.e. small numbers of women, over 15 different SECMs covering very large geographical areas), where the time of birth is, for the most part, unpredictable. Despite such issues, this research method gave me the opportunity to observe directly the social and physical spaces that enabled the relationship between women and SECMs. The observation of antenatal interactions helped me to explore the possible meanings that were placed on in-labour transfer and what *a priori* agreement was made on this issue. The observation of labour and birth at home provided an extensive immersion in the field of home birth, thus informing my 'thick description' of the field of home birth. My observations of in-labour transfer placed me in a unique position to observe some of the decision-making, communication and interactions of those involved in the process.

6.3.2 In-depth Interview

I conducted 61 in-depth interviews (approx. 42 hours of audio recorded data). I interviewed:

- Women who had experienced an in-labour transfer (n= 25)
- SECMs (n= 15)
- Midwives (n=17) and obstetricians (n= 4) from 3 hospital sites

Ethnographic interviews, focusing on the personal accounts of women and healthcare professionals, produced data that provided legitimate sources of knowledge about their social world and their experiences of in-labour transfer. This is consistent with my philosophical stance of social constructionism.

Ethnographic interviews are described as unstructured yet formal and focused (van Maanen 2011). They have been defined as "*a conversation with a purpose*" (Burgess 1984, p.102). This method of data collection provided participants with the opportunity to articulate their own experiences of and insights into the interface of home and hospital birth from their cultural perspective. As noted by Rowley (2010), the data are

grounded in the experiences of the participants; they are contextual, relational and relevant to those telling their story. Data that emerged from the interviews highlighted issues that I might otherwise have overlooked.

Fieldnote 1

The non-descriptive nature of ethnographic interviewing allowed me to ask questions and gather meaning from the participants in relation to what they had shared during the interview process and also from what I had observed in the field. Exploring previously-observed data did not influence the structure of the interview; I conducted the interviews in a manner that encouraged the participant to introduce their issues, to take the lead. However, I used the interview as an opportunity to clarify points in relation to my interpretation. ^{Fieldnote 2}

During the early stages of fieldwork I relied heavily on in-depth interviews as a means of data collection, with women who had experienced an in-labour transfer to hospital. This reflects the initial study protocol, which had not included the observation of home birth. It also reflects the concerns I had in relation to the fieldwork and data sources. Several entries in my reflexive diary highlight that I was worried that I would not observe a home birth, that participants would not consent to my presence, that there was no way to predict if I would observe an in-labour transfer to hospital.

6.3.3 Fieldnotes and Reflexive Diary

The research methods of this study were supported by detailed ethnographic fieldnotes. Hammersley and Atkinson (1995) state that fieldnotes have:

“the power to evoke the times and places of the ‘field’ and call to mind the sights, sounds and smells of ‘elsewhere’ when read and reread ‘at home’”.

(Hammersley & Atkinson 1995, p.176).

Throughout this ethnography I have selected specific fieldnotes in an effort to set the scene and provide descriptions of the context and social processes that informed how this study was conducted (Appendix 2). The extracts are also used to demonstrate the grounds on which the findings were made. The format of the notes varied, from bullet points and logs of conversations to

diary of observations, and written and audio-recorded personal reflections. In Section 6.6.4 (Data collection) I highlight the different techniques I employed during fieldwork to maintain contemporaneous records. The fieldnotes were used to inform some of the questions I asked at interviews (Section 6.3.2), to focus my observations and to inform elements of data analysis.

The fieldnotes also complemented my reflexive diary. In keeping with a method used by Hunt (2001), I used, (when appropriate), three distinct headings to guide my reflections:

Events: A brief description of the fieldwork

Reactions: My feelings about the fieldwork, and my thoughts about the study participants and what the fieldwork had highlighted to me

Relevance: How the fieldwork related to and informed this study

The excerpts from my diary included in the text and Appendix 2 of this thesis provide an insight into the reflexive analysis that was central to this study. Reflexivity as an integral part of critical ethnography has been explored in Section 5.5. In an effort to make the research process visible and add to the rigour of this study, I refer to my diary in order to:

“demonstrate the researcher’s self-awareness of their subjective positioning and acknowledges their influence on the way data are collected and perceived”.

(Allen 2004, p. 15).

In summary, ethnography is concerned with obtaining an insight into people, not just in their physical setting but also in their sociocultural environment, and is regarded as a means of generating some understanding of their interactions and behaviours within that specific environment (Hammersley & Atkinson 2007). The ethnographic methods used in this study enabled me to gain such insights into the interface between home and hospital birth in Ireland. As noted by Pink (2013), there is no “one way to do it” (ethnography); therefore it is important to make explicit the exact research methods used.

6.4 Ethical Approval

I applied for formal ethical approval in December 2010. Approval to conduct the study was obtained from the Faculty of Health Sciences, Trinity College Dublin, and the research and ethics committees of three hospital sites. Further approval was sought following an amendment to the original applications to include additional methods of data collection (observation of labour at home, home birth/transfer to hospital) (Table 3, Appendix 3). As the SECMs are self-employed, there was no requirement to obtain ethical approval from the HSE in relation to their participation; the ethics committee of the university protected their rights and those of the women who participated in the study. Support was also gained from the Community Midwives Association (CMA) and the Home Birth Association of Ireland (HBA). Although there is no formal ethical group at either association, I met with and sent details of the study (including the study protocol and study information packs) to the committee members of both groups.

Table 3: Summary of Ethical Approval

Committee	Comments	Date of Approval
Faculty of Health Sciences, Trinity College Dublin	Approval with minor amendment Amendment to the original application (added data collection methods) – approval with no amendments	February 2011 February 2012
Hospital Research & Ethics Committee (Site I)	Approval Amendment to the original application (added data collection methods) – approval with no amendments	January 2011 August 2012
Hospital Site Research & Ethics Committee (Site II)	Approval (following clarification of points, no amendments required)	April 2011
Hospital Site Research & Ethics Committee (Site III)	Approval with amendments to participant numbers	April 2011

To gain ethical approval, I had to submit a study protocol to the four ethics committees (a predesigned form was supplied by three of the committees) with specific reference to issues of recruitment, informed consent, confidentiality and anonymity, and adverse consequences of involvement in the study. Minor amendments were requested by the university's ethics committee; these related to the wording and layout of the consent forms. One of the hospital committees granted outright approval without any changes. The second hospital site granted approval after I answered questions in relation to the recruitment of 'our' women from 'our' hospital; I addressed these queries by highlighting that recruitment from their site related to healthcare professionals only. Approval was granted without any amendment to the original application. The third hospital site raised no ethical issues; approval was granted on the condition that I increased the number of participants (midwives) from their site. This condition was built into the research protocol. Additional approval (without amendment) was granted by two of the committees in relation to the added data source of observation of labour at home and home birth/in-labour transfer to hospital.

In addition to a written application, one of the committees also requires the applicant's attendance at a committee meeting. At this meeting the applicant has the opportunity to present an overview of their research proposal, drawing specific attention to the ethical issues they addressed in the written application. It also provides the committee members (n= up to 18) with the opportunity to raise any questions or concerns they may have in relation to the research protocol. I mention this here only to highlight some of the challenges that ethnographic researchers face in relation to ethical approval. The membership of this committee was diverse; it was made up primarily of hospital consultants (obstetrics, paediatrics and anaesthetics) but also included a statistician, a member of the hospital's legal team, a member of the midwifery management team, a representative from the affiliated university and a lay person. The chair of the committee, held by a consultant obstetrician, dominated the meeting (I was present for over 45 minutes) and focused on a 'qualitative versus quantitative research' debate, during which I had to defend the methodological stance I deemed appropriate for this study. In fact I had to defend qualitative research in general. My experience, while challenging (and somewhat disheartening given that, in 2011, I naively assumed that the age-old *quant versus qual* argument was obsolete), is not unique; the literature makes reference to "rough rides" (Hedgecoe 2008) experienced by qualitative researchers in relation to ethics committees dominated by medical doctors (Davies et al 2009, Druml et al 2009, Condell & Begley 2012, Newnham et al 2013). Newnham et al (2013) discuss the increasing influence that hospital-based research committees have on research design and highlight the difficulties experienced by ethnographic researchers when their proposals are assessed by criteria relevant to quantitative research studies. It was interesting that the concerns voiced most vocally by members of this committee were not in relation to the ethical challenges associated with this ethnography (as I saw them) but with the "usefulness" of the study's findings, given that it was "only ethnography" (comment made by one of the members of the committee).

This prescriptive process of ethical review at the start of a research project is not without its criticisms (Edwards & Mauthner 2002). I endeavoured to

think through all possible situations that would or could arise (in relation to recruitment, informed consent, confidentiality and anonymity, adverse consequences of involvement), but the very nature of qualitative research means that researchers cannot predict the implications of their data-collection methods in advance. As noted by Monaghan et al (2013),

“... ethical decisions are not something which bureaucratic systems are easily able to accommodate in advance of typically messy and unpredictable fieldwork. In short, ethics are part of an ongoing process that is always subject to negotiation and reinterpretation rather than reification outside the research context”.

(Monaghan et al 2013, p.67).

I was aware of my ethical responsibilities at every stage of the research process, and used reflexivity, the process of doctoral supervision, and discussions with colleagues to guide me through the process. As this chapter continues I will make reference to the ethical issues that emerged and how I dealt with them.

6.5 Fieldwork

In his seminal work *Tales of the Field*, John van Maanen suggests that fieldwork is “a long social process of coming to terms with culture” (van Maanen 2011, p. 117). In order to do this,

“field work asks the researcher, as far as possible, to share firsthand the environment, problems, background, language, rituals and social relations of a more-or-less bounded and specified group of people”.

(van Maanen 2011, p. 3).

I had the privilege of meeting Professor van Maanen on three occasions during the course of this study. The first time I met him, in the very early stages of the research, I looked for words of wisdom. I wanted this renowned ethnographer to tell me how to ‘do’ an ethnography. His words of wisdom amounted to: “*Linda, just get out there and hang out with them and see what’s going on, ask them some questions*”. ^{Diary Entry 3} The remainder of this chapter will focus on this ‘hanging out’: how I prepared for it, where I went, who I observed, who I talked to, the role I adopted in the research field, and what I did with all that information.

This study focuses on the interface of home and hospital birth, the meeting of the field of home birth and the field of hospital birth. For clarity's sake, I will address the fields separately (when appropriate), but I must highlight that the fieldwork was not linear and I moved from one field to the other as the opportunity presented. I will begin with the field of home birth, simply because that is where my fieldwork started. This 'hanging-out' was done in a systematic way that maintained trustworthiness and authenticity at all stages of the research process.

6.6 The Field of Home Birth

The field of home birth (the research location) was wherever the participants (the women and the SECMs) said it was. For the most part, unsurprisingly, it was women's homes. Some of the postnatal interviews were conducted away from their homes, in venues chosen by the research participants (e.g. some of the women had returned to work so it suited them to meet me on their lunch break near their work location, while others came to a venue I had arranged in the local university. A few of the women with young babies wanted to meet in coffee shops or restaurants; I was their excuse to have an afternoon 'out'. One of the women met me on a beach (she wanted to walk but did not feel confident to walk a long beach with her baby on her own).

The SECMs also chose places that they considered convenient. I observed them in women's homes and also in their own homes; we shared car journeys to women's houses; we ate in small coffee shops, and we talked in car parks after meetings and conferences. Regardless of the venue, we were always able to find a private space, where the women and the SECMs said they were comfortable to talk and where no-one interrupted us. I was welcomed into the home of every pregnant woman and every SECM who participated in this study. The women's homes, like all homes, varied. In the write-up of the findings I will draw attention to certain features, not in order to share my opinions in relation to décor but because the issues I raise are relevant to this study (at times highlighting the contrasts between this field and the field of hospital birth). These features include how the venue looked

and smelt different, how the atmosphere differed, how the supports for women were different, how the interactions between women and SECMs were different to the interactions in the hospital, and what was different about them. The field of home birth was not solely comprised of concrete settings or geographical locations; it related also to how birth was viewed, how care was offered, and how relationships (interpersonal and professional) were played out.

6.6.1 Preparation for Fieldwork

As noted in Section 6.4, formal ethical approval was obtained early in the lifetime of this study; however, this did not mean automatic or immediate access to the research sites. Access and site preparation took longer and was more complicated than I had anticipated (reflecting the naivety of a novice researcher). Perhaps, with the benefit of hindsight, I should have initiated means of closer communication with all research sites (home and hospital) while I waited for formal ethical approval.

I approached the committee members of the CMA in relation to the study. The chairperson suggested that I attend one of their meetings and present an overview of the research. Prior to the meeting I wrote to all the SECMs (their names and addresses are publicly available via the HBA website) and informed them that I had been invited to provide information about my study at the next CMA meeting. In this letter I also included a study information pack. My presentation was tabled as an item on the agenda and the chairperson obtained the consent of all members present before I joined the meeting. Due to the nature of *on-call* associated with their professional lives, not all SECMs were present at this meeting; therefore, this was a process I repeated. I conducted five information sessions in relation to the study (April/May 2011). These sessions highlighted the background and purpose of the study, the SECM's role should they choose to be a gatekeeper and participate, and various very practical issues. It is important to note that I was known to some of the SECMs, who knew me in my capacity as a midwife, or in my role as a lecturer in midwifery. I realised the potential for unintended pressure and the fact that our previous encounters might have influenced their decisions to grant me access and participate in

the study. I endeavoured to overcome this by never conducting an information session with only one SECM, thus not placing them in a position where they had, during this phase, to discuss the study on a one-on-one basis. The information sessions were just that – me offering information. If SECMs were willing to participate in any part of the study, the onus was on them to initiate contact with me. While I worried about the impact that my being known had on the study, other midwifery researchers suggest that this does not have to be viewed as problematic and can be an advantage in gaining social access to participants (Stewart 2008, Cheyney 2014a). I suggest that my encounters with the SECMs as a group could have been more intimidating and formidable if there had not been a few familiar faces in their midst.

The SECMs are a diverse group in terms of personal characteristics (e.g. age, marital status, ages of their children, working full-time or part-time as a SECM, number of years practising as a SECM) and their geographical location. Some are based in Ireland's larger cities while others live in small, rural communities. Small pockets of SECMs are dotted around Galway, Cork and Dublin. During the course of the fieldwork, the number of SECMs offering support to women varied from 14 to 17. These midwives have, for different reasons, chosen to offer women a model of care that is a departure from the cultural norm of obstetric-led, hospital-based care in Ireland. They are in some circles revered, and in others treated with suspicion. OBoyle's (2009) work has highlighted that such midwives feel professionally vulnerable and isolated in a maternity service that they see as lacking structural and professional supports for home birth. This was not a group to get excited just because I thought I had a good research idea. This initial phase of site preparation involved recruiting key gatekeepers for three of the data-collection sources of this study, namely:

1. the observation of an antenatal interaction between women planning a home birth and their SECM
2. interviews with women who had experienced an in-labour transfer to hospital
3. interviews with SECMs

As noted earlier in this chapter, an additional source of data collection was added to the research protocol. About eight months into this study, I realised that a more in-depth immersion in home birth was required in that I needed to consider the benefits of observing an in-labour transfer. I struggled with this for a number of months and debated the merits and practicalities at length. ³² In a state of near-despair, I sought the opinion of Martin Forsey, Associate Professor, Anthropology and Sociology, University of Western Australia (via email). His paper, ‘Ethnography as participant listening’ (Forsey 2010), had interested me, and particularly his challenges to contemporary ethnographers who assume that ‘participant observation = ethnography’. His argument highlighted that there are situations when observation is not possible and the value of ‘participant listening’ in the form of ethnographic interviews must be acknowledged. Professor Forsey’s reply suggested that there were two questions I needed to ask myself: What could I learn by being there? and What would I miss by not being there? My response was that I needed to be there, to observe what was happening, to see the actors in their world and their interactions when the worlds of home and hospital birth meet at this intense time of in-labour transfer. Otherwise, I would miss the context, the subtleties of the interactions, the cultural nuances particular to the maternity services in Ireland. I would miss the “*serendipitous learning of being there*” (Pink 2009).

Having made the decision to observe in-labour transfer, the research protocol needed to be adjusted to reflect this. I include this extract from my research diary to highlight the practical concerns I encountered in the research field and the characteristics of home birth that challenge ethnographic observation.

*Diary Entry*⁴

Oh no, I did not like this, not one little bit. How was I going to do this? ‘Just do it’ they said, ‘go to some births’ they said, ‘get the

³² In September 2011 I presented a paper at the Annual Liverpool Ethnography Symposium. The paper, ‘To be there or not to be there ...?’ focused on the dilemmas I experienced in relation to this decision and how I was torn between the need to ‘be there’ and the practical concerns I had in relation to achieving this. I also explored my fears that I would seem like a vulture, hovering over home birth but waiting to pounce should the need for transfer to hospital arise.

midwives to call you' they said ('they' for the most part were ethnographic researchers who were not midwives). Observation of an in-labour transfer, how was I to organise that? Ask the SECMs to call me if someone was being transferred in? Ask the hospital to contact me once they knew a woman was en route? No and no. Too vague, too self-centred at a time of possible emergency, too much to ask of the midwives, a real possibility that my study would not be a priority (naturally), and I would be forgotten, a distinct possibility that I would not get to a hospital in time. The only way around it I can see – I need to be at the homes of women, at home births, to be there if the opportunity to observe an in-labour transfer arises. I needed to learn about transfer to hospital not only during and after the event, I also needed to observe 'the before'.

I went back to the CMA with my dilemma, to try to work through an achievable plan. The SECMs offered practical support. They did not question my presence at a home birth as a researcher or whether that would be acceptable to women (something that had concerned me), but they wondered about me as a researcher who is a midwife. They queried my role should a situation arise where my professional support was needed. They highlighted that, while all of them strive to have a second midwife present during the birth of the baby, this, due to their geographical spread and small numbers, is not always possible. I viewed my primary role at a home birth to be that of a researcher, but was very aware that I am a registered midwife and I could not ignore my professional responsibilities should an emergency situation arise. In Section 4.6 I documented the provision of the National Home Birth Scheme and the requirement to sign an MOU with the Health Service Executive (HSE) and practise within the guidelines defined therein. I needed to sign an MOU, providing evidence that I was 'skilled' to attend a home birth. While some structures now exist in relation to the governance of home birth, at the time no nationally agreed policy on the assessment of clinical competency was in place. Therefore, the appropriateness of my skills and knowledge were assessed at a local HSE level. Local guidelines recommended that I undertook (to name but a few requirements) an Adult Resuscitation Programme, a Neonatal Resuscitation Programme, an Obstetric and Midwifery Emergency Training Course, Venipuncture and Cannulation Programme and Workshops, Suturing Workshops, Study days and workshops on the Assessment of Fetal Wellbeing, and several short

information days provided by the HSE (focusing on, e.g., Documentation, Incident Reporting, and Manual Handling) (Appendix 1).

The study and clinical practice required to prepare for and undertake these programmes and assessments (written and practical) occurred during the summer and early autumn months of 2011. I relied on the goodwill of midwives to support and help me to access the courses and the clinical experience during this time. I was supported by midwives in education, in practice development, in positions of management in maternity hospitals, and SECMS. I signed an MOU in December 2011; this placed me in a position where I could (legally) provide support and assistance at a home birth should the need arise.

In the writing of this ethnography, I find that issues which, at the time, deprived me of sleep now read like the natural 'next phase' of the study. The entries to my reflexive diary expose how vulnerable, as a novice, I felt at this stage of the research process. A considerable amount of time and work went into preparing for an MOU (not only on my part but also on the part of the midwifery support around me); I was concerned that all of this would be in vain if I did not or could not observe a home birth/in-labour transfer. ^{Diary Entry 5} This highlights again the importance and relevance of a research diary and the insight it can offer into the 'doing' of a research study.

Although I formally 'entered' the field and started recruitment and preliminary data-collecting in June 2011 (interviews with women who had experienced an in-labour transfer during home birth), I felt that my preparation for fieldwork had slowed the study down, that I had not planned for observing home birth and what that entailed. In early September 2011 I met Professor van Maanen at a conference and expressed my anxieties in relation to these delays and the impact they were having on my fieldwork. He quickly told me: "*Linda, it's all immersion, that's what we ethnographers do*". It took me a while to really understand his comment in the context of this study; initially I viewed it as something that a generous, experienced researcher says to a novice. Now I see the value of immersion

in a different light. The competencies I had to demonstrate prior to signing an MOU focused, for the most part, on emergency skills (I am not disputing the relevance and importance of these skills; in fact, even if it had not been stipulated, I would have participated in all the life-support and emergency courses prior to entering the field of home birth). It is the emphasis on abnormality and intervention that now holds my interest. For example, a “CTG Workshop” was identified as a requirement, despite the fact that no midwife assisting in a home birth would use the highly technological equipment required to produce a cardiotocograph trace. I had two lengthy discussions with the local HSE officer about the inappropriateness of this in the context of home birth. The officer eventually conceded when I presented evidence to demonstrate that I had attended a workshop on the assessment of fetal wellbeing that had been facilitated by a national expert to meet the needs of SECMs. It is also interesting that the Obstetric and Midwifery Emergency Training Course had to be one of two recognised courses that are facilitated within hospital environments and are relevant to the multidisciplinary teams of hospital-based maternity care. The Emergency Skills Study Day facilitated by members of the CMA with three university lecturers was not considered adequate. The assessment of SECMs by means relevant to midwives working within a hospital-based model of care, the focus on intervention (such as continuous fetal monitoring during physiological labour) indicates the way birth is understood by this HSE area. This approach is also reflected in the findings of this study (Chapters 7 & 8) in the views expressed by hospital-based staff in relation to home birth and how their understanding of birth is entrenched in the medical model of obstetric care.

6.6.2 Stepping into the Field

I tentatively stepped into the field of home birth once ethical approval had been granted.

6.6.2.1 Sampling and Recruitment

The initial participant group, the SECMs, was accessed via a self-selecting process following the purposeful recruitment of all SECMs. Over the course of the information sessions, a number of SECMs asked me to resend the

Study Information Packs (Appendix 4); some of the midwives intimated that they were not sure where they had put the information. One midwife said, very honestly, that she had no time to read all the letters that came in her post and viewed my initial contact and information pack as “*someone else just looking for something*”. She suggested that knowing the aim of the study and what participation entailed provided an incentive to read the information, rather than the other way around. I sent research information packs to the SECMs a second time. The pack contained a letter of introduction, a Participant Information Leaflet (PIL) (participant-specific) and a Consent Form. The PIL contained information about myself and my contact details, a description of the study, and details about confidentiality of information, voluntary participation, withdrawal without penalty, ethical approval and what was required of study participants. Potential participants were asked to contact me (via phone or email) to seek further information about the study or to declare an interest in participation. SECMs were invited to act as gatekeepers for the study as well as participants. Sixteen SECMs indicated that they were interested in acting as gatekeepers and participating in some aspect of the study.

SECMs as research gatekeepers were asked to distribute Study Information Packs to:

1. women in their caseload planning a home birth and who met the study criteria – these women were invited to participate, with the SECM, in an observation session of an antenatal visit
2. women for whom they had provided care in the previous 3-5 years, who had experienced an in-labour transfer to hospital and who met the study criteria – these women were invited to participate in an in-depth interview

The SECMs as potential research participants were invited to participate in:

1. an observation of an antenatal session when they were offering care to a woman
2. an in-depth interview about their experiences of in-labour transfer during planned home birth

SECMs were invited to participate in all methods of data collection; however, they were free to choose their level of participation.

A later phase of recruitment occurred (starting in March 2012) in relation to the observation of labour at home, and home birth/in-labour transfer to hospital. An opportunistic sampling method was employed in that I invited six³³ SECMs in a certain geographical location to act as gatekeepers and participants for this aspect of the study. For the role of gatekeeper, the same process was followed as for the recruitment of women for the observation of an antenatal visit. Four SECMs who agreed to participate were asked to distribute Study Information Packs to pregnant women in their caseload, inviting them to participate in this aspect of the study. The rationale for choosing these midwives was pragmatic, and was influenced by the geographic location of the SECMs and the women in their caseload. By choosing this region I hoped to increase my chances of being present at a home birth/in-labour transfer.

Using a sampling technique that relied on SECMs as gatekeepers in addition to their role as study participants was not without its concerns. Each gatekeeper received 16 Study Information Packs (8 for women in their caseload and planning a home birth and 8 for women who had experienced an in-labour transfer in the previous 3-5 years), with the request to contact me if more were required. Four of the SECMs asked me for more information packs to send to all women in their caseload who met the inclusion criteria; the other midwives did not contact me. This method of recruitment by proxy meant that I had no way of knowing the way the SECMs chose to distribute (or not to distribute) the packs. The SECMs may have had their own biases in relation to the women they did (or did not) approach. I was also aware of the potential for women to feel obliged to participate in the study by virtue of their relationship with the SECMs. In an effort to lessen this concern, the SECMs were asked to give the Study Information Pack to the women and to encourage them to contact me for

³³ Two of the SECMs invited to participate in the observation of labour and birth declined. Both of these midwives were extremely apologetic about their decision and went to great lengths to explain to me why they chose not to participate (I did not seek this explanation). Both midwives supported other aspects of the study.

clarification and discussion in relation to the study before agreeing to participate (consent was revisited at several stages in the field. I acknowledge these limitations; however, I feel that SECMs as key informants and gatekeepers gave me, as an ethnographic researcher, access to women who chose to birth at home that otherwise might not have been possible.

Subsequent recruitment of women who had experienced an in-labour transfer to hospital was achieved through snowball sampling. Women who participated in the study contacted other women who met the inclusion criteria. Six women, participants in postnatal interviews, were recruited in this manner.

6.6.2.2 The Participants

Sixteen SECMs agreed to act as gatekeepers and 15 to participate in aspects of this study. All were given a pseudonym. Formal demographic information about the SECMs was not recorded due to my concerns about the potential compromising of anonymity. It is, however, possible to identify some characteristics.

Table 4: Profile of SECMs

SECMs	Age range	Years a midwife	Years a SECM	Data collection	Pseudonyms
15	34 to 60 years	6 to24 years	2 to21 years	Antenatal observations • n=6	Bridget, Leah, Siofra, Cliodhna, Caoimhe, Naoise
				Home birth / in-labour transfer • n=4	Bridget, Leah, Siofra, Ciara
				Interview • n=15	Bridget, Leah, Siofra, Ciara, Cliodhna, Caoimhe, Naoise, Enya, Eimear, Maeve, Caitriona, Enora, Isla, Rosa, Janet.

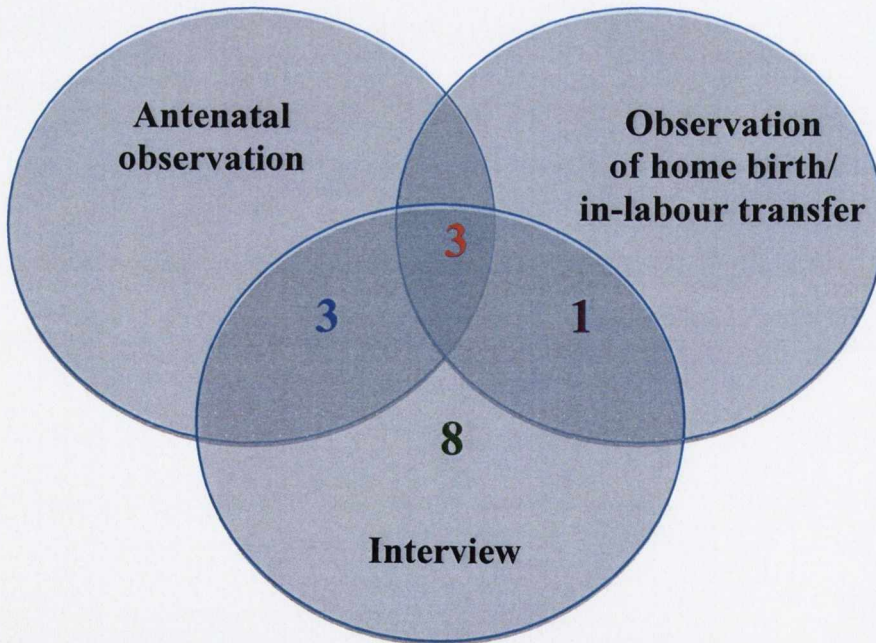
Based on information disclosed during data collection, the ages of the SECMs ranged from 34-60 years. Their years as a midwife ranged from 6-24 years and experience as an SECM from 2-21 years. Some worked full-time as a SECM; some had a part-time caseload and also worked as midwives in a hospital setting. The number of women in their caseload varied greatly; one SECM booked up to eight women per year while others booked 20 to 30. Their academic qualifications ranged from certificate to master's level. Some of the SECMs had received their midwifery education outside Ireland and many had worked in other countries within a variety of models of maternity care.

Fifteen SECMs were interviewed, six SECMs were observed over the course of 32 antenatal visits, and four SECMs were observed as they supported women during labour and a home birth/in-labour transfer to hospital. Table 5 and Figure 1 summarise the data-collection methods and the participation of SECMs.

Table 5: Data Collection and SECMs

Data-collection methods (with SECMs)	No. of SECMs (n=15)	Pseudonyms
Antenatal observation Observation of home birth/in-labour transfer Interview	3	Bridget, Leah, Siofra
Antenatal observation Interview	3	Clíodhna, Caoimhe, Naoise
Observation of home birth/in-labour transfer Interview	1	Ciara
Interview	8	Eyna, Eimear, Maeve, Caitriona, Enora, Isla, Rosa, Janet

Figure 1: Data Collection and SECMs



3	3	1	8
Bridget Leah Siofra	Clíodhna Caoimhe Naoise	Ciara	Eyna Eimear Maeve Caitriona Enora Isla Rosa Janet

Forty-two women participated in this study and all were given a pseudonym to preserve their anonymity. Background information about them, the number of times I met them and other relevant details can be viewed in Appendix 5. I observed 32 antenatal visits with 23 different women. I observed 10 women labour at home; eight had home births, two experienced in-labour transfers and one woman transferred to hospital in the immediate postnatal period. Of these 10 women, I met nine of them antenatally, and nine postnatally. I interviewed the two women who had experienced an in-labour transfer and the woman who transferred to hospital in the immediate postnatal period. I had discussions with the other seven women about their experience of home birth, and any reflections they could offer in relation to my presence. I also clarified any questions that were raised after writing up my fieldnotes. I interviewed 25 women about their experience of in-labour transfer and the interface of home and hospital birth.

Women were invited to participate in all or some of the stages of data collection depending on what was appropriate (e.g. if they were pregnant, if they had experienced an in-labour transfer to hospital previously, if their SECM had consented to participate in the observation of home birth). Table 6 and Figure 2 offer a breakdown of the level of participation for this group.

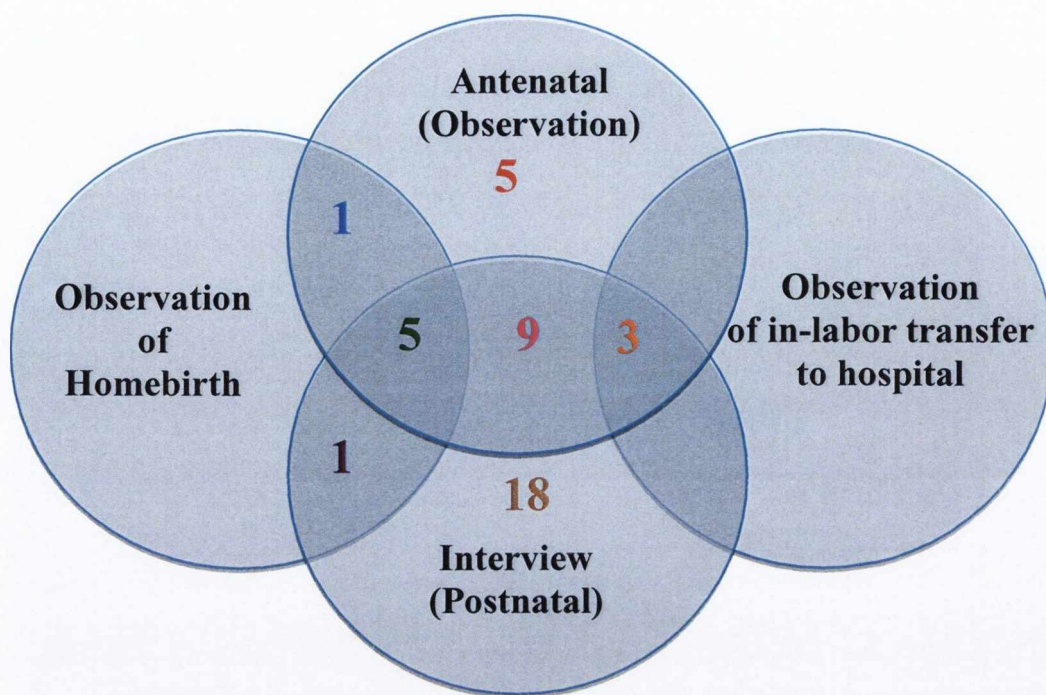
Table 6: Data Collection and Women

Data-collection method (with women)	No. of women (n=42)	Pseudonyms
Antenatal observation Observation of in-labour transfer Interview re in-labour transfer	3	Ailis, Lana, Eibhlin
Antenatal observation Observation of home birth Postnatal meeting	5	Cait, Riona, Iseabeal, Niamh, Sile
Antenatal observation Observation of homebirth	1	Nessa

Observation of homebirth Postnatal meeting	1	Caitlin
Antenatal observation Interview re in-labour transfer	4	Cara, Alannah, Mairead, Jenniver,
Antenatal observation Postnatal meeting	5	Olwyn, Siadbh, Orla, Maura, Roisin
Antenatal observation	5	Tara, Grainne, Laoise, Doireann, Ide
Interview re in-labour transfer	18	Clodagh, Brid, Carys, Gwen, Geraldine, Blaithin, Gilda, Armelle, Aideen, Ethna, Norah, Rona, Cora, Sinead, Ailsa, Aoife, Aoibh, Arlene

Two other women, who had experienced an in-labour transfer, expressed an interest in participating in the study. I made arrangements to interview both. One woman withdrew from the study two days before we were scheduled to meet (she was just too busy with her baby). In relation to the second woman, we had planned to conduct an interview in her house at a time and date that suited her. I got lost *en route* and was not able to make phone contact. I eventually found her house (nearly two hours late) and called to apologise and suggest that we reschedule the interview. At this point this woman decided to withdraw from the study.

Figure 2: Data Collection and Women



5		1		5		9		3		1		18		
Tara		Nessa		Cait		Cara	Alannah	Ailis		Caitlin		Clodagh	Brid	Carys
Grainne				Riona		Roisin	Mairead	Lana				Geraldine	Gwen	Gilda
Laoise				Iseabeal		Maura	Jenniver	Eibhlin				Blaithin	Ethna	Norah
Doireann				Niamh		Olwyn	Siadhbh					Armelle	Aideen	Rona
Ide				Sile		Orla						Sinead	Cora	Ailsa
												Aoife	Aoibh	
												Arlene		

Fifteen women consented to my presence during their labour and home birth/in-labour transfer to hospital. As noted, I observed 10. Table 7 details why I was not present for the other five. Alannah, Mairead and Arlene (who had experienced an in-labour transfer) were interviewed after the birth of their babies.

Table 7: My Non-attendance at In-labour Transfer

Women who consented to participate in the observation of home birth/in-labour transfer	Why I was not present at their labour or births
Alannah	I was not present at Alannah's in-labour transfer – this occurred during the first stage of labour when I was en route to her house from the other side of the country.
Mairead	Mairead transferred to hospital during the early stages of labour for analgesia. The SECM had not called me as she felt it was too early in the labour.
Roisin	Roisin was admitted to A&E for a non-pregnancy-related issue. She went into labour while there and transferred to the maternity unit of the hospital.
Ide	Ide laboured and birthed her baby while I was lecturing.
Arlene	Arelene transferred to hospital at the onset of labour. She went into labour the night before an ECV was planned.

Three other women consented (in early pregnancy) to participate in this aspect of the study but their care was transferred to an obstetric-led model during the third trimester of their pregnancies.

6.6.3 Maintaining Ethical Principles in the Field of Home Birth

The Guidance to Nurses and Midwives Regarding Ethical Conduct of Nursing and Midwifery Research (An Bord Altranais 2007) and the Code of Professional Conduct for each Nurse and Midwife (An Bord Altranais 2000) informed the conduct of this study. The participants all received a Study Information Pack at the recruitment phase. As noted in Section 6.6.2.1, this pack included a Participant Information Leaflet that addressed

confidentiality of information, voluntary participation, withdrawal without penalty, ethical approval and what was required of participants. These principles were upheld in the following way:

6.6.3.1 Respect for Autonomy

Holloway and Wheeler (2010) suggest that the principle of autonomy is upheld, in part, when research participants make a free, independent and informed choice to participate. The participants of this study were asked to sign a consent form prior to each episode of fieldwork. Parker (2007) describes this as the “ethico-ethnographic method” in that consent was not assumed but included into all methods of the study so that researcher and research participants were continually revisiting their understanding of the concept.

Asking SECMs and women to sign a consent form prior to a planned and scheduled meeting was an aspect of fieldwork of which I had prior experience. The first home birth I observed highlighted that obtaining written consent for a more spontaneous event like labour required a different approach. I began to ask women and SECMs who had agreed to my presence at labour and home birth/transfer to sign the consent form during an episode of antenatal care. My experiences in the field highlighted that in some cases obtaining written consent after the onset of labour would have been appropriate, but not in all cases. Although I had obtained written consent I did not assume that it held once labour commenced. All the SECMs called me when the women went into labour. During this phone call I established verbally that they consented to my presence (which prompted one SEMC to reply: “*I’d hardly be calling you if we weren’t happy for you to be here, now would I?*”). Once I arrived at the women’s houses, I applied my experience as a midwife to deem when was an appropriate time to let the women know that I was present and to ensure consent still held. Sometimes the time was not appropriate, as I feared it would be distracting for the woman at the height of her labour. I worried about this ^{Fieldnote 6} and hoped that I was not entering ‘covertly’ into the women’s houses. This worry abated a little when one of the women (who had a home birth) sent me her birth story (I had not known beforehand that she was going to do

this); she described me arriving at her house and being “perfect and fluid in the background”.

I revisited the issue of consent with each woman after the baby was born (for women who had a home birth and the two women who experienced an in-labour transfer to hospital) to ensure that they were still happy to be included in the study. Women who had a home birth made some interesting comments; it amazed me that they were worried that they “had been no use to me”. Remarks such as this prompted me to meet with all women after their home births to discuss aspects of their birth experience that were relevant to the study, and to ensure that they realised the relevance and were comfortable that I was including my observations as data. This also provided an opportunity for me to ask about different ways that I could be ‘in the field’ during labour and birth.

6.6.3.2 Anonymity and Confidentiality

The principles of anonymity and privacy have been observed throughout this study. It was clear on the consent forms that I would maintain confidentiality unless I witnessed a child being harmed or professional misconduct. This was discussed with key gatekeepers prior to entering the research field and a plan was drawn up. The observations of the SECMS’ interactions with women were not focused on competence, but I needed to acknowledge that any observation of care might cause concern for a researcher about the standards observed (Hunt & Symonds 1995). This was discussed with the SECMS and it was decided that the most appropriate response was to bring any concerns to the CMA where matters would initially be addressed as part of the peer review process they built into their membership. No such incident arose.

Each participant was assigned a study number and a study name (male participants were noted across the health professional groups, however, to maintain confidentiality each participant was allocated a female name). All information provided by the study participants is identifiable by their study number only. These files are password-protected and encrypted, and I am the only one who can access them. Support from a professional transcription

service sourced through the university was engaged. Only one person in this service carried out the transcription and they signed a confidentiality agreement. Data have been held in line with the requirements of the Data Protection Act (2003).

All identifiable information has been kept to a minimum, not only in the write-up of this ethnography but also in fieldnotes and my reflexive diary. This confidentiality will also be maintained in any publications arising from this work. Some of the SECMs asked me not to transcribe certain facts that might compromise their anonymity. The world of midwifery in Ireland is a small one; home birth an even smaller one. Even a turn of phrase in a direct quote or a personal characteristic could identify women and SECMs. In an effort to de-identify data, sensitive identifiers from individual cases have been removed or changed (e.g. a women planning her eighth home birth in Ireland is more identifiable than one planning her third, and the geographical locations of SECMs have been altered). Data from two participants of this study are located in more than one participant group. These two participants were allocated different study names in each participant group in an effort to maintain their privacy. Any changes that have been made have not altered the findings of this study and they have been made with the consent of the participants.

This study was not conducted in a covert manner, therefore there are people in the home birth and midwifery communities in Ireland who may be able to recognise certain elements in the research. Obviously SECMs knew which women were participating in the observational elements of this study, and *vice versa*. SECMs may be able to recognise other healthcare professionals. Some of the women when uploading their birth story onto social networking sites identified that they participated in the study. While I endeavoured to protect their privacy by ensuring their anonymity, these are issues over which I have no control.

6.6.3.3 Non-maleficence and Beneficence

In section 6.6.1 (Preparation for fieldwork), I noted that I signed an MOU and why I thought that this was necessary for a registered midwife when

observing home birth. This created both advantages and dilemmas for me in relation to my position during labour and birth, and how I moved between the role of participant and non-participant observer. In Section 6.6.5 I will explore the fluidity of my role in the field; for the moment let it suffice to say that I did “*not forsake necessary intervention or an advocacy role for the sake of research purity*” (Lipson 1991, p. 19).^{Fieldnote 7}

Oakley (1981) cautions against unethical researchers, who use women purely as data sources; with this in mind I endeavoured to find a balance between obtaining information that was relevant to this study and exploiting the participants by ‘using them’ for information. My approach to this lay in constantly revisiting and re-establishing understandings of consent with the research participants, to ensure that we did not lose sight of my role as a researcher and the aim of the study. As an entry in my diary indicates,^{Diary Entry 8} this too was something that I had to balance - “*I know Linda, I know, your questions are for your study ... I’m grand about that, now relax.*” (Jenniver). A requirement of ethical approval stipulated that an interview should be discontinued if any woman became distressed and recommenced once the woman indicated that it was appropriate to do so, or be stopped completely based on the woman’s lead. As section 6.6.5 highlights, many of the women were emotional when they shared their birth stories. I used my experience as a midwife who has, over the years, listened to many women recall birth stories to guide me in this situation. I discontinued the recording on one occasion and let the woman know that I had done so. Through her tears she said - “*don’t mind me, I always get really upset at this bit of the story; now put that recorder back on before I forget where I was.*” (Carys).

There were many issues I needed to consider in relation to my presence in the field, not least my role and the relationships I established. I will continue to address these in the write-up of data collection.

6.6.4 Data Collection

Participant and non-participant observations

I use observation as a technique in my midwifery practice and as a lecturer (on a one-to-one basis, with small groups and during large-group teaching sessions), but I had not used it as a method of data collection prior to undertaking this study. My initial attempts at participant observation were tentative. I was unsure where to begin, what I should focus on, what to write in my fieldnotes, or rather what not to write in my fieldnotes. Everything seemed important, everything appeared to be relevant. Yet I found no comfort in the 'it's all ethnography' mantra offered by more experienced researchers. I joined an Ethnography Platform facilitated by lecturers at a school of business in a UK university. This support group (that is what I considered it to be, although the terms of reference devised by the lecturers may have had a more academic leaning) proved to be invaluable. The group met at 3-4 monthly intervals during university terms. Doctoral students were invited to present (informally) about any aspect of their research that was causing concern or on an issue that they thought would be useful to other students. I was the only midwife at the meetings (bar a radiographer I was the only healthcare professional there); this was advantageous, as I had to be explicit when providing a rationale for the decisions I took in relation to my fieldwork and identify my taken-for-granted assumptions. Some of the group had children or had some experiences in relation to birth, but they did not have the professional knowledge, the midwifery lingo, or the professional enculturation that is part of who I am. This challenged the assumptions that I, as a midwife, sometimes made in relation to my presence in the field and what I observed. ^{Diary Entry 9.} At my request, we carried out some very practical exercises of observation during meetings. This increased my confidence in my skills of unobtrusive observation and writing fieldnotes.

My initial approach to ethnographic observation was broad and descriptive; in a sense this enabled me to “*get started in a setting that may seem overwhelming*” (Emerson et al 1995, p. 26). As my skills developed, the observations became more focused to obtain more specific aspects of cultural meanings that were attached to birth, place of birth and the

relationships and interactions therein. I decided not to rely overly on taking notes in the field. I was concerned that the SECMs would see this as a form of surveillance as opposed to ethnographic observation. Given the very personal time in women's lives that I was observing, I decided that it would be inappropriate for me to sit in a corner writing and writing; I also thought, no matter how discreet my manner, that this might be off-putting for a woman in labour. Instead I made use of a small notebook in which I jotted key words, phrases as well as times and prompts that I found useful when writing the complete notes. I kept my fieldnotes as contemporaneous as possible, often sitting in my car at the side of a road on my way home from an observation, talking into my dictaphone. These notes I transcribed at a later time. I found audio-taping my thoughts gave me a freedom from spellchecking and editing. It enabled me to give a spontaneous description and reaction to my observations in the field. I also used an observational guide for the documentation of specific practices during the observations. This captured the use of body language, nonverbal communications, the demeanour of the women and healthcare professionals. While initially I thought that this helped me to focus my observations and fieldnotes, I abandoned it. I found I was filling it for the sake of it, like a tick-box. I felt that all the information I needed was contained in the way my fieldnotes were recorded.

The formal observations that inform this study focused on specific times in the pregnancies of women who had agreed to participate. The antenatal observations were prearranged at a time deemed suitable by the women and the SECMs. This meeting was guided by the participants and meant that I encountered women at different gestations of pregnancy and some on more than one occasion (Appendix 5). These observations took place, for the most part, in women's homes (I met three women in the house of a SECM; during subsequent encounters we met in the women's houses). Sometimes I travelled to the homes with the SECM; on other occasions I met them at the location. I never entered a woman's house unless accompanied by a SECM, even if this meant parking away from the house until the midwife arrived. During these observations I adopted the role of non-participant observer. Often the first part of the visit was conducted drinking tea. We sat at kitchen

tables, on blankets in the garden, on the floor with children climbing all over us. We sat and they talked and I looked and listened. I attempted to give the midwife and the women space and when possible I did not sit in their direct line of vision; certainly I was never in a position which could be construed as being 'in the middle of them'. During the first few observations I asked the participants to do what they would normally do when they met, and to ignore me. In spite of this all the SECMs and the women spent time 'catching me up' when they deemed it necessary, recounting historical and contextual issues that were relevant to the woman and her pregnancy (and sometimes previous pregnancies). By this ignoring of my request to be ignored, I was reminded that this was not my field or my house and that the actors therein choose what information to include. I did not enter the conversation unless invited. This was often in the form of a question from the SECM (e.g. "*Is that what the research says, Linda?*" "*Have you any experience of this, Linda?*"). I was always honest in my answers. I did not for one minute forget my role as an ethnographic researcher, but I did not think I should ever ignore or pass over a question. In my opinion it would have been disrespectful and rude. I did, on occasions, start my reply with "*Well, with my midwife hat on as opposed to my researcher hat, I think ...*" just to ensure that the reason I was there was not forgotten. The conversations were guided by the gestation of the woman's pregnancy and drew from the previous encounters with the SECM; regardless of this, the subject invariably turned to birth and expectations and planning in relation to birth. I wondered if my presence was influential in this,^{Fieldnote 10} but discussions about birth did not always lead to the consideration of in-labour transfer. I concluded that, if the discussion was being directed a certain way for my benefit, then more emphasis would have been placed on the focus of my study. It was during this stage of the visit that I often observed discussions about interactions with hospital-based staff. Some of these conversations related to referrals made by the SECMs (e.g. one woman was referred for obstetric review because of a concern linked to fetal movements) and 'routine' visits to the hospital (for blood tests at a specific gestation). It was interesting to observe the women recounting their experiences of a planned interaction with

hospital-based staff and the influence of these encounters on women's views of hospital-based maternity care (Section 7.8.2).

The second part of the antenatal visit usually involved a physical assessment of the wellbeing of the woman and her baby (e.g. testing urine, blood-pressure recording, abdominal palpation, auscultation of the fetal heart). I always moved away from the interaction and asked the woman and SECM where they wanted me to place myself during this activity. Sometimes I was asked to remain where I was; on other occasions the woman and SECM moved to a different room (perhaps one with a couch or a bed) and I did not follow. I maintained the role of non-participant observer for the most part unless asked to do otherwise by the SECM and the woman. An example of such an incident occurred when the SECM was unsure of the presentation of the fetus and wondered if it was breech. Following an abdominal palpation, I too believed this to be the case. I relied on my skills as a midwife to support the woman and the SECM during the remainder of this visit as both were distraught at the thought that the baby's presentation was breech at 36+ weeks' gestation (under the stipulations of the MOU, a breech presentation at term inhibits a woman from having a home birth; however, this baby assumed a cephalic position two days later and this woman did have a home birth).

The position of non-participant observer became more difficult to maintain when I met the women on more than one occasion. During subsequent encounters I was frequently greeted and embraced with nearly as much enthusiasm as that shown for the SECM. The women directed questions to me, and the atmosphere was more that of a social interaction. In all cases, tea and coffee-making was attended to before the 'formal' visit began. I used this as an opportunity to be part of the social interaction and banter about the weather, children, or whatever. Once the refreshments were sorted, I used this as a reference point and said something to the effect of "*Now I must get myself into researcher mode*" to herald a change in my role.

I have focused in this section on the SECM and the women planning a home birth, given that they were the participants. However, on occasions, other people present included husbands, partners, mothers-in-law, children and at times household pets. The presence of others added distinct dynamics and interactions to the scene, ^{Diary Entry 11} but it never ceased to amaze me how considerate they were of me and of my research. Children were taken to other areas of the house to play; people busied themselves somewhere else, often with words such as “We need to give Linda and the midwife some space”. I asked two husbands about this, and why I should take precedence over the family sitting together for the antenatal visit? Their replies focused on the value they placed on everything and anything to do with home birth – an interesting point when considered in the context of why people agreed to participate in this study. ^{Diary Entry 12}

The observations of labour and home birth/in-labour transfer to hospital were organised in a different manner and were less structured as, obviously, the onset of birth could not be predicted (see Table 6). By October 2012 I was concerned that the number of observations was not adequate. On the advice of key informants and gatekeepers, I went ‘on-call’³⁴ with the SECMs. An intensive period of immersion in the field followed during which I was on-call from December 2012 – July 2013.

I relied heavily on the involvement of the SECMs during this process. Once they were aware that a woman was in labour they contacted me, usually by phone rather than a text message. This was for two reasons: a conversation allowed us to plan our ongoing contact and, secondly, I was afraid (especially at night) that I would not hear a text. Guided by the opinion of the SECM, I would start my journey to the woman’s house or wait by the phone. As noted in Section 6.6.3.1, on entering women’s homes I endeavoured to strike a balance between not disrupting the scene and ensuring that the actors were aware of, and comfortable with, my presence. During this participation I moved along a continuum between participant

³⁴ ‘On-call’ commenced when a woman’s pregnancy was at 37 weeks’ gestation and ended at birth of the baby / 42 weeks of pregnancy.

and observer. For the most part I sat (often on the floor³⁵) apart from the woman and her supporters, where I could observe what was happening, make brief entries in my little notebook and not be in the way. However, I remained at a distance that allowed me to see non-verbal cues: non-verbal communication between the SECMs and the women and also any cues that the midwife made to indicate that she needed me to do something. I did any practical tasks asked of me, such as making tea, tidying, getting children ready to go to grandparents' houses, fetching and carrying, filling the birthing pool; little things that I thought were helpful. I found great comfort in these tasks; maybe it is the midwife (or even the nurse) in me, but sitting and observing without *doing something* did not come easy to me. Passing the SECM a towel was better than sitting there feeling useless! At times the SECMs drew on my experience as a midwife and asked my opinion about an assessment or a decision that informed the care. ^{Fieldnote 13} I addressed these in the manner noted earlier in relation to my participation at antenatal visits. My movement between participant observer and observer was guided by situational ethics, in that any midwifery engagement on my part was underpinned by the principles of non-maleficence and beneficence (e.g. assessing liquor for meconium, initiating the initial steps of neonatal resuscitation, preparing for transfer to hospital). Any blurring of roles was pragmatic and did not impinge on any ethical principles.

Appendix 2 and Chapter 8 provide extracts from the fieldnotes in relation to eight home births and two in-labour transfers. These were written reflexively and make reference to what I observed, the relevance that this had to this study and my role as a participant observer.

Interviews

The interviews in the field of home birth occurred between June 2011 and February 2014. Over this period, recruitment was not continuous and the interviews were interspersed among the other methods of data collection. As noted earlier, these interviews took place at a time and location chosen

³⁵ When possible I asked antenatally about the plan for the layout during labour, what room was going to be used, and where the birthing pool would be, so I could plan where to locate myself.

by the SECMs or the women (Section 6.6). I had met some of the women prior to the interview (eight women had participated in other strands of data collection for the study); and 18 I met for the first time at the time of their interview. I had, in different settings, met all the SECMs prior to their interviews. These interviews ranged from 25 minutes – 2 hours in length.

Conducting an interview did not intimidate me in the way that the initial episodes of observation had. I had previously undertaken research using the semi-structured interview as a means of data collection (although this was the first time I had conducted an ethnography). I planned to develop as natural a dialogue as was possible, one that imitated a conversational process. To do this I drew on my skills of communication developed over the years in midwifery practice and education.

Thirty-eight of the 41 interviews conducted in the field of home birth were audiotaped. All interviews with women were recorded. Two of the SECMs chose not to be recorded but consented to me taking fieldnotes. During an interview with another SECM I did not set my dictaphone correctly, and did not realise this until after the event. This SECM went through fieldnotes that I wrote in relation to the interview and added anything she felt that I had missed. After approximately 10 interviews with women I started to carry my dictaphone in my hand as I went to meet them. During the initial part of our social interactions women often embarked on rich descriptions of their understandings of birth and home birth. I quickly became immersed; therefore having the dictaphone in my hand helped to remind me to turn it on.

I opened each interview with a set question that triggered a personal narrative. The first question I asked women was: “Tell me why you planned a home birth”; the first with the SECMs was “Tell me why you became a SECM”. I chose these questions because I felt that they would break the ice and provide a useful background and personal context. From there I attempted to facilitate the telling of the participant’s experiences rather than leading the conversation. The participants were invited to talk about issues that they considered relevant and I probed with open-ended questions when

appropriate. This unstructured technique enabled me to explore the subjective meaning that individuals give to their experiences of in-labour transfer and the interface of home and hospital birth.

I avoided the notion of a rigid interview guide and *a priori* themes in the early stages of data collection, but as categories emerged they were incorporated into later interviews (in Chapter 5, I noted how this guided the study toward a critical ethnography), (Appendix 6). While maintaining flexibility, I endeavoured to facilitate an interview technique that elucidated personal experiences but also provided enough consistency for comparison between participants, so that similarities and differences became apparent. I interviewed the two women whose in-labour transfers informed part of the observational data. This provided rich data concerning their perspectives on their individual experiences. I also used this opportunity to explore what I had observed (or not observed) during the interface.

I maintained contemporaneous fieldnotes in relation to interviews. The positive feelings that I expressed after an interview often contrasted with my opinion when listening back to the tapes. Of major concern was the length of time women spent recalling the minutiae of their labour and birth stories. With hindsight, what appeared fascinating in the field seemed to meander off focus. I reviewed the way I asked questions and wondered if what I considered to be a flexible and facilitating technique was in fact just vague. I spoke at length with my supervisors about this employed a different technique in a subsequent interview; I kept bringing the participant back to what was in line with the specific aim of the study and attempted to focus her on her experience of transfer whenever I felt she was widening the scope of the interview. I felt that this made the interview stilted and forced, and felt akin to exploiting the woman, to just 'using her' for information, as discussed in Section 6.3.3.3 (Non-maleficence). I abandoned this approach mid-interview (I stopped the interview and apologised to the woman, who interestingly had not been in the slightest way perturbed, and asked to recommence the interview). During the analysis of these interviews I began to appreciate again the rich data contained in women's labour and birth stories and how they gave cultural context to their experiences of transfer.

6.6.5 Reflections in the Field of Home Birth

The aim of ethnographic fieldwork is to gain an insight, from both emic (insider) and etic (outsider) perspectives of the culture of a specific group (Hammersley & Atkinson 2007). This process is often described dichotomously, but in my experience it was more fluid and complex. I assumed a role that moved along the continuum from participant to non-participant observer, from an insider to being an outsider, in an effort to gain an in-depth perspective. Sections 6.6.3 and 6.6.4 describe how I managed this process. Reflexive considerations were vital throughout to ensure I maintained integrity in my engagement with the research field and the research participants as I negotiated my position in the field.

6.6.5.1 Getting In

In order to gain access to the field of home birth, I relied heavily on the gatekeepers. Sections 6.6.1 (Preparation for fieldwork) and 6.6.2 (Stepping into the field) detail the ways I achieved this and what was involved. The SECMs were hesitant in their initial engagement with recruitment. I noticed that the majority of potential participants who contacted me were women who were eligible to participate in the interview exploring experiences of in-labour transfer (these women were not pregnant and therefore not current recipients of care from the SECMs). As I became more known to the SECMs,³⁶ they demonstrated a willingness to recruit for, and participate in, the other elements of the study, and the uptake of pregnant women consenting to participate increased. I was invited to observe antenatal visits and observe the woman-SECM dyad. Diary Entry 14

Going 'on call' added another unexpected dimension to my presence in the field; sharing the experience of 'on call' intensified my connection with the SECMs. The unpredictability of the onset of labour, for example, would lead to excitement, at times frustration and even downright grumpiness when timings did not go to plan or interfered with our lives. Diary Entry 15 This gave us a common language, a starting point for conversations. It brought our communication to a level I had not experienced when I was 'just' a

³⁶ The CMA invited me to their quarterly meetings.

midwife from the university. I perceived the midwives to be more open in their communication. Outside the formal recorded interviews, SECMs provided me with broader contextual details about the ways in which the culture within which they were working influenced their practice (e.g. Section 8.7.2.1). The critical tone of some of their comments assisted the critical approach this ethnography took. Sharing these experiences was often accompanied with comments such as “*Don’t forget to write that down for your study*”.

This was a very gradual process. I was under no illusion: I had to *earn my stripes* before I was allowed to observe home births. A willingness to be on call was not in itself enough; I knew that the midwives were deciding if I was a suitable character to let into the world of home birth, given some of the questions they asked me. Many of them questioned me on my midwifery background and my experiences. I am sure the fact that I had planned a home birth for myself increased my acceptability. One of the more senior SECMs and a key informant was really the first to support the study publicly. This appeared to instil confidence in some other SECMs. It is a small world where information and stories are shared, and peer review and reflection is supported and encouraged. While women’s confidentiality was not breached, word soon ‘got out’ that I had been present at home births. This had a knock-on effect and suddenly I was contacted by other SECMs, saying in effect: “*Linda, I have this woman due on xxx date and she is interested in participating in your study, do you want to look at your diary?*”^{Diary Entry 16}

In section 6.6.2, I highlight my concerns in relation to unintended pressure and the strategies I put in place during recruitment to try to limit the likelihood of women participating in this study solely because they had received the Study Information Pack from *their* SECM. However, it would be naïve of me to think that women would allow me, a stranger, to observe their home birth if it was not for the relationship they had with the gatekeeper. During our early interactions it was clear that the women took their initial cues from the SECMs: “*If Bridget [name of SECM] thinks you are alright, then you must be ok*” (Nessa). A period of probation followed;

during this time the women were not shy about asking me questions, such as:

How long are you a midwife? Why did you decide to teach? Are you going to become a SECM? What did you think of home birth? How many home births have you been to? Do you have children yourself? What ages are your children? Did you have home births? (the latter was the one question they all asked me).

This was my first experience of study participants bombarding *me* with questions. I answered the questions honestly; if I expected these women and their families to share their experiences with me, I felt that it was the least I could do. When women asked me about my views on home birth, I always pointed out that most of my midwifery experience had been in a hospital environment and that my opinion related to supporting the development of the maternity services so that women could have a choice, rather than preferencing one model over another.

6.6.5.2 Fitting In

In section 6.6.4 I detailed how I carried out the observations; I described the lengths I went to in order to ‘blend in’ to the field of home birth; I adapted an overt but unobtrusive presence. I also took trouble to ‘fit in’ (I use the language of Burns et al 2012 here as it describes aptly what I did). Signing an MOU and going on-call went some way to fitting in with the SECMs; my reflexive diary highlights strategies I employed in the field to establish rapport and so help me to fit in with the women. My reading of midwifery ethnographies conducted by other lecturers in midwifery (e.g. Dykes 2004, Stewart 2008) highlighted the importance of a dress code to reflect the researcher role³⁷ and the ‘smart casual’ approach that these researchers adopted. I decided to dress in a similar manner and dressed as I would when lecturing. During my time in this field, I did revise the ‘smart’ aspect and

³⁷ The observations for both these ethnographies were conducted in hospital settings; therefore, these researchers had to choose between the dress code of the staff (a uniform), the hospital managers (a formal suit) or the clothes they wore in their role as a lecturer (smart casual). In an effort to identify clearly their role as researcher in the field, both choose to wear clothes they would wear to their university job.

leant more toward the casual. This rethink was prompted by comments made by some of the participants. (One woman asked me to go out 'the back way' when I was leaving her house, as she was worried that my dress, heels and leather satchel would suggest that I was a social worker; as it was, her neighbours thought her choice to have a home birth irresponsible. Another woman told me that I looked like a schoolteacher rather than an SECM; I do not think that this was intended as a compliment). My attire at home births was governed by comfort. Regardless of clothing or phase of data collection, I wore my university ID around my neck at all times while in the field. I did this for two reasons: first, for identification purposes so I could highlight that I was who I said I was and, secondly, to provide a physical reminder that it was my role as a researcher that underpinned this interaction/observation. I adopted a different approach in the field of hospital birth in that my dress code did not have any casual aspect.

I was not aware of another tactic I used to 'fit in' until teased about it by one of the SECMs. When I entered women's houses with SECMs, I was very conscious of being the outsider, almost intruding on their pre-existing relationship. Unbeknownst to me, I seemed to immediately search for something to establish a link between myself and the woman. This often centred around motherhood (e.g. if there were toys in the house I would make a comment like "Oh we have that toy in our house too"). I wondered why I was doing this. Was it to establish rapport? Was I trying to get myself into the 'Mommy's Club' and be accepted more readily? Or was it so that I felt like less of an intruder in the 'Woman SECM Club'? It was probably a mixture of all these motives. Once aware of this tactic, I tried to find a balance between not being too familiar and not being a mysterious researcher who was expecting everything of the women but not offering any of herself in return.

6.6.5.3 How I was Viewed

During the six-month intensive period on call, there seemed to be a change in the SECMs' perception of me and my role. Instead of the phone calls telling me that the midwife had a woman in her caseload who was interested in participating in my study, an SECM asked: "*Linda, I've a woman due on x date, are you around to do 2nd on call?*" (Ciara). I was quite taken aback by this and worried that I had 'gone native'. A regrouping with my supervisors reminded me very quickly that I had not lost sight of my primary role as a researcher but that it seemed a blurring of boundaries in relation to my researcher/midwife roles was occurring. My diary entry reflects the dilemma that this caused. I did not want to seem unhelpful or selfish by not supporting the SECM who had supported me, but at the same time I needed to remain overt and remind the SECM of my role in the field, and to avoid a woman feeling under pressure to participate in the study. Another way of viewing this is that I had been accepted into the field of home birth and that my observations were a genuine reflection of the culture.

How the women saw me depended on the number of times that we met. I think that participating in more than two observation episodes risked role ambiguity and the women began to view me as an apprentice to the SECM (but, interestingly, not as an SECM). The women highlighted aspects of their care that they were particularly positive about, almost as if they were using them as a learning tool for me: "*Did you see how she did that, Linda, how she guided me there? That was really helpful.*" While trying not to be monotonous in my reply I would relate their comment and the actions of the midwife to the study. This actually became useful as the women would, at times, highlight the impact of aspects of their care or their interactions with the SECM that I might otherwise not have been fully aware of. One woman (in her blog) referred to me as "*the other midwife, the researcher*"; given the participant-observation role that I had assumed during her home birth, I could not really dispute this.

In ethnographic terms I was an outsider with an etic perspective, but I think that some information was shared during the interviews because of my

personal and professional biography. I felt that I was viewed as an empathetic outsider by some of the women and as a researcher with an insider's perspective by the SECMs. There are advantages and potential disadvantages in relation to both. While these aspects added to the quality and depth of the data I collected, I was aware that this could also lead participants to share more with me than they had initially intended. All the participants were given the opportunity to withdraw any of their comments, some participants asked me to alter one or two phrases that they had used. I was viewed as a non-judgmental safe outsider by some of the women, a sounding board to listen to them as they made sense of their birth stories. Women spent long periods talking about their birth stories, and some did this very emotionally. I took great care not to comment on the issues women raised; however, from recorded assessments of my teaching over the years I am aware that my facial expressions can, at times, clearly convey my emotions. The women did not ask me direct questions about my views of aspects of their care. This surprised me, but I needed to consider if this was because they were conscious of my role as a researcher or if my face mirrored their feelings and so they felt no need to ask. When I reflected on this, I realised that a number of the women had in fact asked questions about their care in an indirect manner: for example, "*Is there anything I can do to avoid this [an instrumental birth] the next time?*" "*How will I arrange that my SECM will stay with me the next time?*" "*Will I be allowed to have a home birth the next time?*" "*How will I book at a different hospital for the next birth?*"

These questions I answered, and I shared my professional experiences. On a few occasions I suggested that their SECM was best placed to provide more in-depth answers and encouraged the women to make contact with them.

When the interviews came to their natural conclusion and the dictaphone was turned off, the dynamic often moved away from data collection to one of reciprocity. The women sought my professional opinion. Although I presented myself as a midwifery researcher with a specific interest in models of maternity care, the questions for the most part related to breastfeeding and childrearing issues. The SECMs knew that I attended several national and international conferences in relation to midwifery and

home birth and I was their 'link' to relevant information or useful contacts. Due to my background in midwifery education I was asked to help facilitate study groups and workshops. How I viewed myself in the field of home birth also warrants comment. Burns et al (2012) succinctly highlights the reflections of a researcher who is an "outsider with a professional insider status". I could relate to this title and described myself as an "outsider who kind of has a professional insider status" (in that I am a midwife, signed an MOU, was present at home births and had at times to assume the role of second midwife, but I am not an SECM with a caseload). The entries in my diary reflect my feelings and thoughts throughout this time, ^{Fieldnote 17} not only in relation to the processes of the study but also to the way I reacted to and felt in the field. I enjoyed being present at birth. I enjoyed seeing normal birth; I was reminded of the 'buzz' and the exhilaration I had felt during my early exposures to birth. I ventured into the somewhat familiar yet unfamiliar (given that most of my experience as a midwife occurred within a hospital) field of home birth and enjoyed it, as an outsider with the professional insider status that facilitated my acceptance. I was acutely aware, throughout the fieldwork, of the risk of going native and how this would impact on the study. Throughout the data-collection and data-analysis phases of the VCRM, doctoral supervision helped me to maintain my critical gaze. I will make explicit the way I used the VCRM in section 6.8, but first I will address the field of hospital birth.

6.7 The Field of Hospital Birth

There are 19 publicly funded maternity units in the Republic of Ireland. Four are standalone maternity hospitals, and the remaining 15 units are part of a 'general' hospital. The number of births in each unit varied from less than 2,000 per year to just under 9,000 in 2012 (ESRI 2013). The units differ not only in the numbers of women who access their services but also the services they offer. Some are centres of tertiary referral, some are major teaching hospitals. Two of the hospitals offer a home birth scheme; others offer DOMINO/Early Transfer Home Scheme, midwife-led clinics. As noted in Chapter 4, models of maternity care that are not obstetric-led are not offered across all units. The catchment areas also vary, with greater geographical distance serviced by some of the more regional units. Three

maternity units in Ireland were selected for this study. These sites were selected because all accept women who are referred by an SECM and therefore have practitioners with experiences of offering care when an in-labour transfer during planned home birth occurs. The three sites were different (in terms of some of the characteristics listed above), but this study was not set up as a comparative ethnographic study. The units were chosen to give depth to this study.

In keeping with my records concerning the field of home birth, I aim to offer enough information to avoid being vague while at the same time not drawing attention to features that will make the sites easily identifiable. To this end I decided (when necessary) to describe the units in a generic way. I also refer to the study sites as hospitals as opposed to maternity units.³⁸ It felt more natural to say a hospital-based midwife or a midwife working in a hospital; a maternity-unit-based midwife conveys the impression of a midwife working in a midwifery unit (or within a midwife-led model of care) and I wanted to avoid this confusion.

The age of the hospitals varied, as did their infrastructure and facilities. I paid particular attention to the entrance areas (the first impression the building offers to women); some were modern and inviting while others were dark and dreary, with poor lighting and dark yet bland décor. Most of my time in the hospitals was spent on or near the labour wards. I use the title *labour ward* rather than *delivery suite*. For me, labour ward more accurately describes the layout of the environment; *suite* suggests more the home-from-home maternity units described by Symon et al (2008).

The labour wards had similar layouts, while the number of 'labour and delivery rooms' varied (influenced by the size of the hospital). They were located around a central gathering area, a desk of some description (sometimes titled the 'nurses' station'). This tended to be like an open-plan office or reception area where all staff gathered when they were not in the rooms with women. It was also the first stop for everyone who arrived at the

³⁸ From this point onwards I will use the word 'hospital' when referring to all of the maternity units.

labour ward; they stood there and waited until seen to or ushered somewhere else. The layout and size of the rooms varied slightly but tended to be similar. While some attempt had been made to paint the room bright colours, with pictures on the walls and pretty curtains on the windows, their clinical function was not disguised. A bed formed the centrepiece and, depending on the space, a resuscitaire was the other main feature. All the 'hospital paraphernalia' were clearly visible: drip stands, CTG machines, suction and oxygen cylinders and tubing, and trolleys, in various corners of rooms. Packages of sterile instruments and IV fluids were on shelves or hidden in presses that lined the walls. I asked women who had experienced an in-labour transfer of their impressions; many said that they did not even see the environment until after their baby had been born; others made comments such as "*It was what we thought it would be*" (Jenniver) I attempted to see the environment anew, as if I was entering for the first time. It was busy, with staff in scrubs moving in and out of rooms and around the 'station'; this movement was all at a fast pace. Phones were ringing, bookings being made, referrals being organised; doctors coming and going ("*What woman do you want me to see?*"). 'Labour progress' would be updated on a big whiteboard, women's names being rubbed out and new ones quickly inserted. Lots of noise, but very little of the labour sounds I had become accustomed to hearing in the field of home birth. The rooms were nearly always full, but I did not hear women call out, make the noises of labour, the noises of birth. Most of the noises I heard were the voices of the staff as women were 'coached' or 'directed' as they birthed. This environment (this field) looked and sounded very different to that for home birth.

The hospital-based staff I interviewed were asked to pick a venue that suited them. Three of the obstetricians chose their offices and one an office on the labour ward. All interviews were scheduled to take place during their working day. The venues chosen by the midwives varied. Some took place in their homes, others in private offices in areas of the hospital. One took place in a change-room after the midwife's night-duty shift. I met some of the midwives in quiet cafés, booked meeting rooms in a local university for others. Some of the midwives wanted the interview to take place during

their lunch breaks at work. As their work was not predictable, this often meant that I was waiting around for lengths of time or that interviews had to be rescheduled. Because of this some interviews were carried out via phone or Skype.

Similar to what was stated about home birth, the field of hospital birth was not solely comprised of concrete settings or geographical locations, it related also to how birth was viewed, how care was offered, and how relationships (interpersonal and professional) were played out.

6.7.1 Preparation for Fieldwork

Preparation for fieldwork involved for the most part negotiating site access. I met with the Directors of Midwifery (or equivalent) at the three sites. All of them were aware of my research prior to our meeting; they had reviewed my proposal as part of the site's ethics and research committee or the committee had made them aware that my study had been granted approval and site access. Two of the directors agreed to act as gatekeepers for their sites, while the other nominated a midwife in a senior managerial role. I was not a complete stranger. I was well known to one of the directors and the other two knew of me. I have no doubt that this had an impact on their decisions to grant me access. My professional status also appeared to be a persuasive factor. One of the directors commented at the end of our meeting: "*You know, Linda, it's great to see one of our own doing a PhD; we'll do all we can to help.*" I have no professional allegiances to that particular site and, by 'one of our own', I can only assume that she was talking about me as a midwife.

This preparation for fieldwork and site access seemed swift and uncomplicated. From prior experience, though, I was aware that access and support at a managerial level does not automatically mean ease with recruitment or that the research will be accepted by other members of staff.

6.7.2 Stepping into the Field

My presence in the field of hospital birth occurred alongside the fieldwork for home birth. I commenced recruitment for the midwives in July 2012 and the interviews with midwives took place between September 2012 and September 2013. Recruitment with obstetricians began in September 2013 and interviews were conducted between October and December 2013. I observed two in-labour transfers to hospital.

6.7.2.1 Sampling and Recruitment

The participant groups were accessed via a self-selecting process following a purposeful sampling method. The gatekeepers placed Study Information Packs (identical to those used in the field of home birth, but participant-specific) in the post slots of the midwives and obstetrician in their organisation who were eligible to participate (see Appendix 4). The potential participants were invited to contact me to obtain further information about the study or to arrange an interview.

Recruitment was slow; a month after the gatekeepers distributed the information, contact was initiated by two midwives. A gatekeeper suggested the lack of response could be the result of two factors. First, they questioned if the summer was the best time for recruitment (practitioners on holidays, etc). The second reason was site-specific. In the previous year midwives in this hospital had participated in a qualitative study and felt the findings did not present them in a good light. Some were very upset when the researcher presented at a national midwifery conference (many of the participants were in the audience) and included details that the midwives deemed to identify the site. The gatekeepers were very supportive when I raised my concerns about the lack of interest. One of them re-sent the Study Information Packs; this generated a more positive response from this site. The other two gatekeepers allowed me to conduct information sessions at their sites and allocated a midwife in a Clinical Midwifery Manager (CMM2) position on the labour wards to support me with this. The impact of the information sessions mirrored my experiences during the initial phases of recruitment with the SECMs, and midwives and obstetricians began to show an interest and ask me questions. Thirteen midwives were recruited using this

technique, and a further four were recruited via snowballing. Following one round of recruitment and the information sessions, two of the gatekeepers decided to send the Study Information Packs to obstetricians in their hospital via their secretaries. Ten information packs were re-sent; four obstetricians expressed interest and participated in the study.³⁹ As with the SECMs, I was known to some of the hospital-based practitioners in my capacity as a midwife and a lecturer. The potential for participants to feel obliged to participate, and thus to experience coercion in this field also existed and I put in place structures that mirrored those I described concerning the recruitment of the SECMs.

The recruitment in relation to the observation of in-labour transfer occurred in November 2012, to coincide with the intensive period of on-call I previously described. The gatekeeper at one hospital site was asked to place Information Packs in the post slots of midwives and doctors in their organisation working on the labour ward. The Information Pack focused on the observation of in-labour transfer to hospital, highlighting that I would accompany the woman and SECM to the hospital in the event of a transfer and be present to observe the initial interactions of all those involved (not participating in the interactions in any way). An invitation to participate, an opt-out consent form, my contact details and a stamped envelope addressed to me were included in the pack. All potential participants were invited to contact me or, if they decided to sign the form, to post it to me. I did not receive any opt-out consent forms. I contacted the gatekeeper on two occasions to ensure that she had not received any of the opt-out consent forms. She had not received any and confirmed that she had distributed them. Members of staff from this site participated in interviews, during the course of the interview they confirmed that they were aware of all aspects of the study.

³⁹ One obstetrician asked me, at interview, if I had any “recruitment issues”, suggesting that my timing was either “a blessing or a curse ... because the Aja Teehan case homebirth is so topical they’ll all want to say their piece or they’ll have had enough fighting with the homebirth people”.

6.7.2.2 The Participants

Twenty hospital-based midwives (HMWs) participated in this study. I conducted 17 interviews, and four midwives were observed during in-labour transfers to hospital.

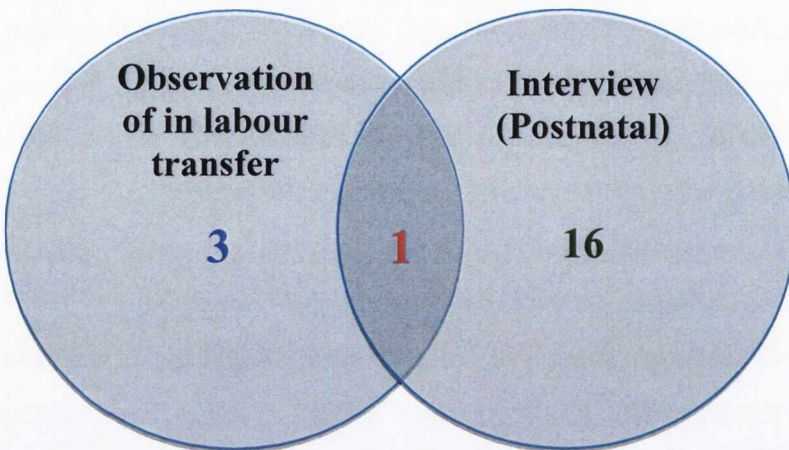
Some details about the midwives are shown in Table 8; again, these are limited in an effort to maintain anonymity.

Table 8: Profile of Hospital Midwives

Midwives	Age range	Years a midwife	Data collection	Pseudonyms
20	25 – to 52 years	2 to 20 years	Observation of in-labour transfer (n=3)	Ava, Maude, Attracta
			Observation of in-labour transfer and interview (n=1)	Saoirse
			Interview (n=16)	Shiona, Mafra, Clair, Piala, Myrna, Ita, Alva, Mona, Iseult, Fiona, Dara, Dervla, Mary, Tegan, Catherine, Helen

The ages of these participants ranged from 25–52 years, and their years as a midwife from 2–20 years. Some were educated in Ireland, others in the UK. Their professional qualifications went from certificate to master's level. Some had experience of models of midwife-led care in other jurisdictions.

Figure 3: Data collection and Hospital Midwives



3	1	16			
Ava Maude Attracta	Saoirse	Shiona Myrna Iseult Mary	Mafra Ita Fiona Tegan	Clair Alva Dara Helen	Piala Mona Dervla Catherine

I interviewed four obstetricians. Table 9 offers an overview profile. These participants had experience of being in lead clinical positions in their hospital.

Table 9: Profile of Obstetricians

Obstetricians	Age range	Years an obstetrician	Data collection	Pseudonyms
4	Over 30 yrs	Over 15 years	Interview	Eileen, Brenda, Sheena, Triona.

6.7.3 Maintaining Ethical Principles in the Field of Hospital Birth

As noted in section 6.6.2.1, the Participant Information Leaflets for this study addressed confidentiality of information, voluntary participation, withdrawal without penalty, ethical approval and what was required of participants. These principles were upheld in the field of hospital birth in a manner that was identical to that for the field of home birth.

6.7.3.1 Respect for Autonomy

The procedures used to obtain consent prior to the interviews were similar to those described in section 6.6.3. I decided that an opt-out method was the most practical way to achieve consent for an event that was not guaranteed (I could not know in advance if any women would experience an in-labour transfer to hospital) or predictable. Although I had not received any opt-out consent forms, I did not assume that consent held once I was present in the hospital, and on both occasions re-established verbal consent. I drew on my experience as a midwife to judge an appropriate time to approach the staff about this, making great efforts not to disrupt the organisation of care. The decisions made by midwifery managers during the transfers meant that I was not 'allowed' into the labour room with the woman and the SECM, but the midwives offering care invited me to sit at their station and gave me permission to continue my observations and talk to them. I re-established consent to include the observations as data before I left the field.

6.7.3.2 Anonymity and Confidentiality

The principles of anonymity and privacy were upheld as previously described for the field of home birth (section 6.6.3.2). As noted previously, this study was conducted in an overt manner; therefore, my presence in the field of hospital birth at the time of transfer was made obvious to the hospital-based staff, the women and SECMs who participated in the study. When writing my fieldnotes and findings I removed any factors about the participants or the site that could be perceived as making them identifiable.

6.7.4 Data Collection

Non-participant observations

Appendix 2 provides extracts from my fieldnotes and reflexive diary concerning the two in-labour transfers I observed. On entering the field of hospital birth, I assumed the role of non-participant. On both occasions I drove the woman and the SECM to the hospital, assisted them to the labour ward and then parked the car. ^{Fieldnote 18} The SECM told the hospital staff that I was on my way back and they expected my arrival. Identifying who I was when I entered the ward provided an opportunity to establish if the staff were aware of my study and if they objected to my presence. As mentioned,

I was asked not to enter the labour rooms and so I did not directly observe the immediate interactions, but I was invited to observe from a central position in the ward. As an obvious outsider sitting in a typical staff-only area, I introduced myself to all members of staff who were present and highlighted why I was there. The SECM and the HMWs kept me informed about what was going on and the plan of care proposed. Once the woman was comfortable I was invited to rejoin the SECM. I stayed in the labour ward until the SECM deemed it an appropriate time for us to leave.

From my location I was able to observe the interactions of the HMWs and their discussions around in-labour transfer, decisions made about the woman's care, and the communication between the midwives and the SECM. As near to the event as access allowed, I observed the interaction that, while not played out in the labour room, related to the interface of home and hospital birth.

Interviews

During the interviews with the hospital-based healthcare professionals, I adopted the same format I previously described in relation to the field of home birth (section 6.6.4). These interviews ranged from 20 minutes to an hour in length. All the interviews with obstetricians were recorded, and 14 of the interviews with midwives were recorded (the other three midwives did not want to be taped but gave me permission to take notes). I opened each interview with a trigger question to provide background and personal context: *"Tell me about your experiences in relation to home birth."* This was followed up by open-ended questions, which invited the participants to discuss their experiences of in-labour transfer (Appendix 6).

6.7.5 Reflections on the Field of Hospital Birth

The field of hospital birth was more familiar to me as a midwife and a lecturer. I moved in and out of this space comfortably and approached it with greater ease than that of the field of home birth. It was, therefore, important that I remained aware of my past enculturation in the field of hospital birth and how this affected my interpretation of what I saw and was told (see section 6.8.). Hammersley and Atkinson (1995) caution that it is

essential that ethnographic researchers avoid the “*comfortable sense of being at home*” (Hammersley & Atkinson 1995, p.115) and maintain their critical awareness. My sense of *being at home* related to environment and also to my engagement with the hospital-based participants.

6.7.5.1 Fitting In

I spent a considerable length of time gaining access and acceptance in the field of home birth; this is reflected in the attention it receives in the write-up of this ethnography. The entries to my reflexive diary highlight that access to the field of hospital birth seemed (to me at the time) less complicated; my knowledge of the culture and workings of hospital life assisted me in this. I knew what was expected of me and did not challenge these expectations. I knew what language to use, how to negotiate the intricacies of a hospital hierarchy, how to dress, where to stand, when to approach midwives and when to wait. This, like other aspects of insider/outsider knowledge, brought with it both advantages and disadvantages. It meant I could access the sites and be accepted, be non-obstructive during observations, and understand the cultural underpinning of hospital-based practitioners’ experiences. I wondered, however, if my insider knowledge inhibited me from observing the initial interactions that occurred in the labour room. I was asked not to go into the room by the midwives in charge. I responded to the situation as it arose in the field, and did not dispute the request but respected it. Would another researcher, perhaps one without personal experience of working under the hierarchies of hospital-based labour wards, have questioned this and as a result have gained access to the room? My reflections have not provided a definite answer. However, I balance this potential disadvantage with the suggestion that it was my professional status that assisted me in gaining such access and immersion to the fields of home and hospital birth.

6.7.5.2 How I was Viewed in the Field

My reflections on my emic/etic perspective in the field of home birth match my reflections on my interactions with HMWs; I felt that some midwives viewed me as an empathetic outsider, and others even as an insider. The interactions with midwives were infused with comments such as: “*Sure you*

know yourself, Linda", "You know the score around here", "Look it, Linda, you know what it is like in hospitals", as though I was in collusion with them. I had to probe further to ensure that there was no ambiguity, and that I did understand their experiences.^{Diary Entry 19} The views they offered about the field of hospital birth, and the ways in which this influenced their ability to practise as a midwife provided contextual details that informed the critical approach of this ethnography.^{Diary Entry 20}

Interviews with obstetricians did not offer such professional affinity. I was treated with initial suspicion by three of the participants. Prior to the interviews they asked me questions about my research, what underpinned my questions, and how had I been received in the research field. One obstetrician showed a definite curiosity about my presence at home births and was amazed that as a researcher I was "*allowed into the inner circle*". As these interviews progressed, the atmosphere became more relaxed. It was more formal than the atmosphere at the other interviews but was not stilted. One of the obstetricians commented after the interview: "*That wasn't too bad. I didn't know what it was going to be like, if you were going to devour me because you wouldn't like what I had to say.*" (Brenda, Obs). When asked what was meant by that, the participant replied: "*I feel, as an obstetrician, no matter what I do it won't be right, this is one group I'll never please, so all they end up doing is shouting at me or about me.*" The interview with the fourth obstetrician was, without doubt, the most uncomfortable interview I have conducted thus far in my career as a researcher. I perceive that attempts were made to demonstrate that the participant viewed me as inferior. This took several forms, including being late for the interview without explanation or apology, insisting that we conduct the interview in a shared area even though I had pre-booked a private office, belittling statements about the study, questioning why a midwife would undertake a PhD, and silences during the interview that I believed were intended to intimidate me. This interview challenged my skills as a researcher, but it was worth the effort as it yielded extremely valuable data.

Reflexive accounts of how I viewed myself in the field of hospital birth were maintained. The idea of “outsider with a professional insider status” (Burns et al 2012) was relevant to my reflections. In section 6.6.5.3 I noted that I was conscious of going native during my research work in the field of home birth; I was also aware of this here. I listened back to the interviews with the midwives, and read my fieldnotes. I could relate to some of the experiences the midwives shared. I had been that midwife at some stage in my career. Seeing anew these experiences, with the outsider’s critical gaze, was supported by VCRM.

6.8 Data Analysis

Using the model as suggested by Mauthner & Doucet (1998), enabled me to explore the experiences of the participants of this study in relation to the people around them and the broader social and cultural contexts in which their experiences occur. This exploration was achieved by a four-stage process of simultaneously reading and listening to gathered data. The focus of each phase changes; it is guided by a different question so that the researcher attempts to uncover the story from the perspective of all participants (Edwards 2001). The fourfold set of readings of data from fieldnotes, interview transcripts and my reflexive writing was adapted and applied to the integration of each of the data sets for the overall analysis in this study (See Appendix 7 “Examples of my adaptation of VCRM”).

I had the opportunity to attend two workshops facilitated by Natasha Mauthner, which focused on VCRM and the practical application of the tool. This proved invaluable and supported me to apply the framework of analysis to the data generated within my ethnographic fieldwork. I received very pragmatic feedback from Professor Mauthner in relation to my work.

6.8.1 Readings in the Four-stage Process of VCRM

1) The story and who is speaking?

During the first reading, as suggested by Mauthner and Doucet (1998), I read for the overall ‘story’ (the plot and the subplot) as offered by the research participants and as recorded in my field notes. Main events, characteristics of the participant’s experiences and recurrent themes were

noted. The stories cannot be separated from the context, therefore the cultural context in which the experiences occurred remained central to the stories.

Mauthner and Doucet (1998) suggest that the researcher must also explore their own responses to the ‘stories’ and identify how they are “socially, emotionally and intellectually located” in relation to the participants of the study (Mauthner & Doucet 1998, p.127). Due to my personal and professional history, many elements of the participants’ stories were familiar. I was, therefore, in danger of filtering these stories before creating a space to hear them. This first reading helped me to hear and see what the participants were saying in an attempt to experience the familiar as strange. It identified the complexity and diversity in the participants’ accounts of their experiences (within as well as across participant groups). As the plot of the stories emerged, the experiences of the participants and my responses to the context and the narrative/observations were recorded and integrated within the analysis. Reading for the stories allowed me to embrace the inter-subjectivity and multiple realities of the participants and to reflect on my subjectivity and my personal and professional assumptions. Diary Entry 21

Table 10 An Example of Reading 1 (SECMs)

Codes	Sub-Categories	An example from the data	My response to the narrative
<p>You were considered stropky if you wanted to stay</p> <p>Not allowed to stay</p> <p>Some midwives adamant that you don't stay</p> <p>Not worth the fight</p> <p>Not invited to stay</p> <p>Some midwives apologized but they could not let you stay</p> <p>Can be frosty and fraught</p>	<p>Caught between women and hospital midwives</p> <p>You have to take a step back</p>	<p><i>“being there gives me a chance to ensure that they don't over-do the interventions if they are not needed”</i></p> <p><i>... you're in the middle of both of them. And she's [hospital midwife] saying “she needs an ARM” and the woman is looking at you going “but why do I need an ARM, I said I didn't want to have one”. And you see both sides ... so at this stage I ... am just honest with everyone ...</i></p>	<p><i>The SECMs and the women talk +++ about the benefits of the ongoing presence of the SECM after transfer. Women talk of the support it offers them, the continuity of care. The SECMs are more pragmatic in that they see the need not only to support the women but also the belief to ‘keep an eye’ on the intervention focused hospital staff. How interesting is this, and also so interesting that they</i></p>

You pretend you don't notice	Pretend you don't notice	<p><i>"This is not the time [at transfer] to take on the system, no, this is the time to make sure it is as good as it can be for this woman. I'd worry that going in there being awkward or, you know, shouting the odds, it just won't work ... and then you have the woman stuck in the middle of all of that"</i></p>	<p><i>do it in a subtle non-confrontational manner.</i></p> <p><i>A lot of the midwives in this study talked of the ways they worked to gain entry to the hospital. Prior to gaining entry these SECMs had to gain acceptance which was based almost on terms and conditions set down by the hospital-based practitioners (doctors & midwives).</i></p>
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2) *In what body? – the voice of the 'I'*

The second reading focused on the participants and on the way they saw themselves and their experiences and how they thought others perceive them. Issues of personal identity, autonomy, professional status, emotions, opinions, actions and intentions were considered at this stage, how the participants positioned themselves in relation to the understandings of birth in Ireland. As suggested by Mauthner and Doucet (1998), I highlighted *I*, *we* and *you* throughout the transcribed texts and the participants' movements between these accounts. This enabled me to see how the participants viewed themselves in the wider context of the culture of birth, where they placed themselves in the *them (they)* and *us (we)* associated with the field of home birth versus the field of hospital birth, and how they felt that this influenced the way others viewed them. This reading offered an analysis of power as noted in the everyday lives and stories of the participants.

Focusing on the *I* (and when the participants used *I* and when they used *we* or *you*) provided me with insights into how the participants located themselves within the ideologies of birth; for example: "I said to her, **we** [the obstetricians and midwives] just have to get on and get her delivered, that is just what **you** [a midwife] have to do at that stage" (Clair, HMW).

Table 11 An Example of Reading 2 (Obstetricians)

Codes	Sub-Categories	An example from the data
<p>It's like it's my fault I'm held responsible</p> <p>I didn't cause this</p> <p>I didn't make this happen</p>	<p>I get blamed</p>	<p><i>"I think these people are just very distrustful of hospitals, of obstetricians ... they are just distrustful of me"</i></p>
<p>They want to blame me</p>	<p>I didn't stop their home birth</p>	<p><i>"Oh goodness it is not my fault that things have not gone according to plane, yet women come in (some women) come in with such an attitude, ready for a fight, like it is my fault that her labour has taken this course and it is my fault she needs synto or whatever"</i></p>
<p>I am responsible It's my call It's over to me then It's my case I am in charge</p>	<p>I'm keeping everyone safe</p>	<p><i>"Sometimes you need to tell the midwife 'it's not your call anymore so butt out here' ... it's very difficult if you have someone who doesn't want us to intervene when we feel that it's the right thing to do, based on the evidence ... and our experience, we know what needs to be done and it's our responsibility to do it".</i></p>

3) *Telling what story about relationships?*

The third step involved exploring relationships and how relationships can influence experiences. This stage provided an in-depth way to revisit the research questions in that it focused on the relationships between all the participants of this research study and highlighted the influence that their interactions can have on the transfer process and the interface of home and hospital birth. In this reading I explored the way in which the participants spoke about their relationships with other groups within the study and also observed the interactions that occurred in the research field. It was in this space that I became aware of power and authoritative knowledge, and how they played out in the data. I listened and I observed – who had the dominant voice, who held the power, how did this influence the interface.

While this led me to adapt a critical approach to this ethnography, I needed to avoid an inflexible application of this perspective on the data in ways that

might narrow my interpretation. Had I not drawn on VCRM and the framework offered by Mauthner and Doucet (1998), this might not have been possible. VCRM allowed me to explore the influence of power yet remain open to other understandings (e.g. trust).

This also allowed me to explore the participants' understandings in relation to moving from the 'what is' to the 'what could be', which is at the core of critical ethnography.

Table 12 An Example of Reading 3 (HMWs)

Codes	Sub-Categories	An example from the data
<p>Difficult - Midwife not doing what the woman 'want' / think should have happened</p> <p>Women don't want interventions</p> <p>Poor, strained, angry, not pleasant</p>	<p>Expectations?</p>	<p>"... she [the woman] barely even talked to me, it was as if she sort of felt I couldn't help her, it was like I didn't understand that her plans had changed or I wouldn't get what she was talking about, so she didn't ask me anything, she directed all her questions to her midwife [SECM]. It was very hard, I think that's why I remember it so well because I felt out of place, I didn't feel the way I usually do when I'm in work. I was doing my best to try and meet her needs given that things had changed ... I wasn't stopping her from having a normal birth, it was just the way that things had changed"</p>
<p>Them and US</p> <p>Blame</p> <p>Women looking for someone to blame</p> <p>Midwives feel like the women treating them like it is their fault</p>	<p>Atmosphere Challenging</p>	

4) *In which societal and cultural frameworks?*

The final phase focused on understanding people in their social environment and their complex relationships with others and was guided by the theoretical underpinnings of this study. This step involved placing the participants within the relevant cultural context and social structures that inform and influence their perspectives, intentions and activities.

Remaining cognisant of the complex relationship between power and knowledge in the context of birth in Ireland, rather than just explain observable experiences, this reading enabled me to view the data through a

critical lens and critique the conditions that enabled these events. This reading supported my critique of the macro-political issues within the organisation of the maternity services; this is a perspective inherent in critical ethnography. ^{Diary Entry 22}

Table 13 An example of Reading 4 (Women)

Codes	Sub-Categories	An example from the data
<p>Other people put fears in her head re home birth</p> <p>People thought that she was bonkers</p> <p>People thought that she was Brave</p> <ul style="list-style-type: none"> • Brave • Wondered why people kept telling her that • What was she brave about? What was she missing? <p>Midwives told her that she was brave</p> <p>People thought that home birth was dangerous</p>	<p>Brave & Bonkers</p> <p>Homebirth – risky and dangerous</p>	<p><i>“... and you just know from the way that they look at you when you say you are having a home birth. You just know that they don’t approve and that they think it’s not the way it should be. You shouldn’t have to deal with that negative reaction ... it’s so difficult and upsetting”</i></p> <p><i>“... another time I was just going in for routine bloods and urine and that, and she said “oh you’re very brave now, you’re very brave - this girl is having a home birth – Jesus I wouldn’t do that now”, you know that kinda attitude ... it made me not want to go into the hospital, it didn’t make me not want my home birth</i></p> <p><i>“And so the midwife was doing the scan and we got talking about stuff and so I told her that I was going to have a home birth. She looked a bit horrified to be honest and said “you are brave aren’t you, I don’t know if I’d do that” and I sounded like I was doing something that was just so off the Richter scale, you know, something that was so irresponsible and dangerous altogether”</i></p>

6.8.2 Managing the Data

During the early phases of this research study, I had proposed to use the computer package Nvivo to manage the data, and attended two study days

in relation to using the software package. However, I found that it fragmented the data and focused my initial analysis on identifying codes and categories before I was adequately immersed in the data. A manual process, using paper copies of fieldnotes and transcripts and Windows Word documents (with highlighted and coloured texts) supported my immersion and enabled me to move through the four steps of VCRM more fluidly and in more depth. This allowed me to carry out and see each stage of the analysis process clearly. The decision to discard the support of a software package in the age of technology did concern me, and how this would be viewed (and critiqued) by readers of the study. However, I feel that I am 'in good company' and that my concerns were warranted given that Fiona Dykes (Dykes 2004), Denis Walsh (Walsh 2004) and Mary Stewart (Stewart 2008) also chose non-technological methods to support immersion in their ethnographic data.

6.9 Assessment of the Study – Issues of Rigour

The issue of rigour is somewhat contentious in an ethnographic study underpinned by epistemological and ontological perspectives that recognise the existence of multiple realities, therefore denying the claims of 'one' truth. I am aware, however, that for this research to have any impact on or at the very least to inform the provision of maternity care in Ireland, I must be able to make some claims to its veracity. Rigour, in so far as it confirms the legitimacy, integrity, and competence of the research process (Tobin & Begley 2004), supports my efforts to do this.

The term *trustworthiness* is used by Lincoln and Guba (1985) to describe rigour in qualitative research studies. I hope the writing of this ethnography thus far has highlighted the efforts I have made to maintain the trustworthiness of this study. I have followed Lincoln and Guba's (1985) guidance that:

“the basic issue in relation to trustworthiness is simple: How can an inquirer persuade his or her audiences (including self) that the findings of an inquiry are worth paying attention to, worth taking account of? What arguments can be mounted, what criteria invoked, what questions asked, that would be persuasive on this issue?”

(Lincoln & Guba 1985, p. 290).

Oakley (2000) suggests several criteria as central requirements of trustworthiness, including: clarity in relation to the sample and methods of data collection; maintaining ethical standards throughout the stages of the research, and consistency of the methodology and methods with the philosophical perspective underpinning the study. I have, throughout this and the previous chapter, demonstrated my adherence to these standards in an effort to maximise the trustworthiness of this study. I have been explicit about my philosophical and theoretical perspectives and how these have informed my interpretation of the findings.

The different readings and steps of VCRM assisted the systematic approach I took to data analysis. Fieldnotes from the observations made of the contexts in which data were collected, and transcripts of interviews, were read and reread, an inherently rigorous method that tests assumptions made during analysis and interpretation. Multiple participants from multiple sites informed this research study, and using participant and non-participant observation interviews, reflexive journaling and documentary evidence together demonstrate the comprehensiveness of context and interpretations of the data.

Data were collected and analysed from each participant group simultaneously. This allowed for assumptions generated through analysis to be developed, modified and clarified by participants in each group. As noted earlier in this chapter, I met several of the participants on more than one occasion, and a number of participants took part in more than one element of data collection. This allowed me to identify to the participants the emerging issues as I saw them and ascertain their opinions of my interpretations. In keeping with contemporary doctoral ethnographic studies undertaken by other midwives – e.g. (Dykes 2004, Stewart 2008, OBoyle 2009) – I decided not to present the analysis back routinely to the participants after completion (unless they had asked for it) for further respondent validation. Given the multiple voices represented (in and across the participant groups) and the critical approach of the ethnography, I considered this to be an inadequate demonstration of trustworthiness. Holy (1984) suggests that such member checking is susceptible to participants

liking positive things written about them and dismissing the not positive. Silverman (2010) states that this does not promote trustworthiness but risks hagiography (designed to serve a specific political agenda). I do not agree completely with this distrustful attitude, but, without devaluing and dismissing the subjectivity of the participants, it did have an influence on my decision. I was also concerned that the research process would be never-ending, if participants offered a second version of their reality. Why should this be more or less valid than the first version?

Samples of interview were analysed independently by my supervisor (an expert researcher) to explore whether similar analysis would be achieved to verify the emerging data. This exercise was valuable in that the analysis was comparable. Throughout this research process and the writing of this ethnography, I have recorded and detailed my decision/audit trail (Appendix 7). Central to the audit trail is my reflexive positioning within the study and my role in the research field. Demonstrating an audit of the moment of conceptualisation is, however, difficult. The support provided at doctoral supervision sessions helped me to make my insights transparent (Appendix 2).

During the final year of my doctoral study I had the opportunity to present papers on various aspects of this study (Appendix 8). The reactions of members of the audience (midwives and non-midwives) and the feedback I received afterwards demonstrated that the findings of this study resonated with their experiences. ^{Diary Entry 23} This was not limited to women or midwives in Ireland. For example, at a conference in Brussels, a participant said: "*Linda, that is it, that is how I felt, it is like that for us [in Germany] too.*"⁴⁰ The extent to which the findings were found to apply to midwives in other jurisdictions was a welcome point of feedback.

⁴⁰ Comment from a homebirth midwife following my paper at Optimising Childbirth Across Europe. An Interdisciplinary Maternity Care Conference, in Brussels, April 2014.

6.10 Stepping Out of the Fields

Moving away from the hospital research sites coincided with the end of data collection. Stepping out of the field of home birth was not so easy to draw to a conclusion and in a sense I did not want to. To walk away from the field of home birth, to me, smacked of 'Thanks, I got what I came for and now I am out of here'. I was conscious, however, that I needed to step back; I needed to find a reflective and analytical space that related to the interface of home and hospital birth. I was not able to enter this space fully while I remained immersed in one of the fields. I handled this with the honest approach that underpinned all my encounters with the research participants. The reciprocity that underpinned our encounters during the research process will be facilitated again in that I have ongoing plans for dissemination and future research in relation to models of maternity care.

As an afterthought, given my personal and professional self and my role in supporting the education and development of midwives, can I ever step away from the fields of birth?

6.11 Summary

In this chapter I have described the methods I used to collect, collate and analyse the data. I have described my preparation for fieldwork and my initial impressions of the field of home and hospital birth to account reflexively for the decision I made in the research field and the research process generated. I have set the scene for the findings of this critical ethnography.

(For Fieldnotes and Diary Entries please see Appendix 2, Pages 428 – 433)

Chapter Seven: Constructing Home Birth.

“How we talk about, write about, and present ethnographic research to others is part of the extended research relationship we establish with respondents ... in this sense, ethnographers are story-tellers”

(Grills 1998, p.14).

7.1 Introduction

This chapter introduces the findings and presents the journey into the world of home birth that is integral to this study. The data informing this chapter emerged from observations, interviews, field notes, and my reflexive writing, and will provide an ethnographic exploration of the context in which in-labour transfer occurs for the participants of this study. Earlier chapters have provided a cultural critique of the provision of maternity care in Ireland; this chapter will highlight how the cultural constructions of birth are played out in real lives and how they affect the interface of home and hospital birth.

The participants of this study have contributed to the findings as a whole; however, these findings do not reveal comparable experiences. They demonstrate the extent of debate on the socially constructed understandings of birth and of place of birth. In keeping with my epistemological and ontological position, this study elucidates the shared cultural expressions and variations across and within the participant groups, and thus contributes an understanding of the complexities of interactions at the interface of home and hospital maternity care in Ireland.

This and the subsequent chapter provide a descriptive account of experiences that emerged from the data which were deemed influential during in-labour transfer. Presenting the findings in this manner is in keeping with the traits of VCRM as recommended by Mauthner and Doucet (1998); I will describe how the participants of this study spoke of themselves before I position their experiences in the wider socio-cultural context of the maternity services and birth in Ireland.

The chapter is divided into two parts. Part I introduces the participants by providing an insight into their understanding of home birth,⁴¹ encapsulated in the headings ‘*Why a home birth?*’ and ‘*Healthcare professionals’ views of home birth*’. These understandings occupy an influential position during reactions to, and interactions during, in-labour transfer. Part II explores the journey toward home birth for the women in this study. The themes explored draw on the interactions between women and healthcare professionals, and address them under the headings of ‘*Discourses of risk*’, ‘*Moments of power*’, ‘*Foundations of trust*’ and a ‘*Lasting impression*’.

Part I

7.2 Why a Home Birth?

As noted in Chapter 6, each interview opened with a set question (which was specific to each of the participant groups, Appendix 6). The question put to the women participants – “Tell me why you planned a home birth” – triggered a personal narrative that highlighted not only why the women made this choice but also provided insights into their perceptions of models of maternity care and healthcare professionals, and their expectations in relation to home birth.

The reasons why these women planned a home birth varied, but the themes that emerged from the data mirror, for the most part, the published literature. Women’s choices were guided by and intertwined with their knowledge of home birth and the maternity services in Ireland. Their knowledge also influenced their expectations of home birth and what they hoped for their subsequent birthing experiences. It is difficult to explore these in a linear manner; I acknowledge that the themes that emerged are interconnected and underpin all aspects of the stories that the women shared.⁴²

⁴¹ The data displayed in this chapter contest the claims of the dominant discourse to represent unanimous understandings of birth in Ireland, and highlight how the current provision of maternity care is not meeting the needs of all women. All the women who participated in this study planned a home birth (n=42), while the experiences of 39 healthcare professionals also inform the findings. Therefore, it is not possible to identify all the participants associated with each theme covered in this chapter.

⁴² In order to add to the context of the study Appendix 9 documents my diary entries before entering the field and my assumptions about the women who planned a home birth. It also

7.2.1 'I planned a home birth because...'

Three categories emerged from examining the reasons why the participants in this study planned a home birth: i) '*I wanted a home birth*', ii) '*I did not want a hospital birth*' and iii) '*There was no other option available*'. The first two are closely related but there are subtle differences, some of the women planned a home birth because they believed that the philosophy of home birth matched their own reading of birth. Others suggested that a home birth would help them to avoid the elements of the maternity services that were not in keeping with their philosophy, the aspects that they did not see as supportive of normal birth. These findings have played out in the literature, where similar reasons for planning a home birth have been offered by women in other jurisdictions (See Chapter 9). The third category is unique to this study and provides a critique of the organisation of maternity care in Ireland and the options that are available to women.

7.2.1.1 'I wanted a home birth'

The data that inform this theme provide an insight into the women's expectations of home birth. I divided these data into four subthemes: '*My house, my space*'; '*Where else would I be? I'm not sick, you know*'; '*I wanted an SECM looking after me*'; '*It isn't just the birth at home; I want all that comes with it*'. This enabled me to focus on the specific understandings of birth and the women's expectations.

'My house, my space'

I wanted a home birth because I thought it would be - nice, quiet, calm, warm, comfortable, and magical. The environment and the atmosphere were held as important to women as they identified what they thought would meet their needs during labour and birth.

highlights some of the data in relation to women's knowledge of home birth and interactions with GPs during the early stages of pregnancy.

Niamh and Bridget (SECM), (observation):

Niamh has it all worked out, she will have the birthing pool in one area of the house in front of the fire and a blow-up bed with cushions in a different room in case she needs a cooler temperature. She has bought covering for her sofa so she can lie down if she wishes but doesn't want to go upstairs to her bed (in case she labours during the night and her noises wake the other children).

Home birth was planned for their homes, 'my own space', and therefore the women were able to arrange this space in whatever manner seemed appropriate to them and would best meet their needs. Many⁽ⁿ⁼⁴⁰⁾ had thought through where in their house they wanted to labour and birth, the layout of the room, where they would place cushions and bean bags, where the birthing pool would go, the space they could walk in, the space they would lie in, and what piece of furniture would be a supportive leaning post. They had also planned the level of light and temperature, what smells and noises they wanted around them, what food they wanted to eat and who they wanted to be there. It was their home, their space, so they were able to decide and plan how this space would be. This, for some women⁽ⁿ⁼¹¹⁾ was the *magic* they associated with home birth.

Roisin and Bridget (SECM), (observation):

Roisin was so excited about her plans for her home in preparation for birth. That session was all about candles and colours and creating an atmosphere. Roisin has put a lot of thought into the appearance of the environment, the almost wonderland scene she wishes her baby to be born into. I found it difficult not to draw from my personal experience here, given that for me these are things that I did not consider, nor did I notice when planning my home birth. I was more focused on supports and strategies for 'coping', but maybe this is just a good example of the different supports that are of value and importance to different women.

Others⁽ⁿ⁼²³⁾ described a more pragmatic approach; "I know what will work for me" (Siabh). The familiarity of home was important, in that the women knew what they would draw comfort from. This comfort was at a physical level but also met their emotional needs.

Rona:

Just that it's my experience, it's my pregnancy, it's my birth, it's my baby. I wanted to do it kind of my way, in a way, in the comfort of my own home ... just having all that, I just found it a real comfort.

Orla (observation and discussion):

Orla is very definite about her needs during labour and the way she wants. She articulated that her home is where she wants to be, this is where she feels safe. She wants to be surrounded by people of her choosing, with familiar things that will make a stressful situation as familiar and as comforting as it can be. She kept referring to familiar people in a familiar place where she felt in control.

Tara and Clíodhna (SECM), (observation):

That word safety again, "I know what will make me feel safe". Tara talked of feeling safe in her "known space".

Feeling safe with the familiar was something that all the women talked of in relation to their planned place of birth. The feeling of safety these women associated with the known was also transferred onto their relationships with their SECM. This emerged time and again from the observations and will be explored in much greater depth in Chapter 8. This ownership of space and control within it was a theme that held across the phases of this study. While women associated their home space with positive experiences, experiences in other spaces were held in contrast to this (see, for example, Section 7.8.2). Ownership of other spaces was associated with healthcare professionals. Most of the women⁽ⁿ⁼³²⁾ who participated in this study felt, during interactions with hospital midwives (HMWs) and doctors and within hospital environments, that they were no longer in control. This sense of having to conform to the norms of a different system and the power sources at play in the space of others (during women's antenatal and birthing experiences)^{Fieldnote 1} will be explored in Sections 7.6.1 and 8.10.

▪ **'Where else would I be? I'm not sick you know'**

The women⁽ⁿ⁼¹⁶⁾ who had always considered that home would be their planned place of birth responded with somewhat quizzical expressions

when I asked them to tell me about the choice they had made. For some it seemed like an obvious decision.

Gwen:

I have never really been into hospital my whole life. Both my parents are homeopaths so I've never really been to a doctor really so the idea of giving birth in hospital just was alien to me, really strange and I didn't really like the idea of it ... giving birth in a, you know, where people are sick ... the bright lights, the stress, the noise.

Iseabeal and Bridget (SECM), (observation):

I sat there and one by one members of this large and extended family filled the house. Homemade soup wafting in the air being stirred by Iseabeal's daughter, someone else schooling the younger children using a map of the world as a reference point, sawing of wood could be heard out the back. Cloves being used to soothe a sore tooth that was beginning to ache. (I felt like I was in an episode of 'The Waltons'!). And in the middle of it all, holding court, Iseabeal. She asked me about myself, where I had been as a midwife. "Hospitals, we don't go there when we are pregnant, only when we are sick," she said.

When I probed further, this 'obvious choice' revealed itself to be underpinned by the women's understanding of pregnancy and birth.

Aideen:

I just see birth as a non-medical process, so I don't think you need to be in the hospital unless there's a medical reason, that's where I'm coming from on it.

Childbirth was viewed as a physiological process, a normal life event. These women talked of not being sick, of not needing to be treated as if they were sick. They did not view pregnancy or birth as an illness, nor did they believe that it would be supportive to have it treated as one. So if they were not sick, why would there be any reason to go to hospital? "*I'm just having a baby you know*" (Ide).

▪ **'I wanted an SECM looking after me'**

Planning a home birth made it possible for the women to have around them all the supports they deemed necessary for a positive birthing experience. It

meant that they could organise and plan their environment and the people they wanted in this space. The presence of an SECM was regarded as a significant part of this experience. This was especially the case in the data that emerged from women who had previous knowledge of or exposure to home birth. The women believed that the SECMs and all they represented were in keeping with their understanding of birth. At several junctures in this study, women suggested that their beliefs about birth mirrored those of the SECM. This was important in that women⁽ⁿ⁼³⁵⁾ stated that they wanted a midwife who would support and respect their desire to have a normal birth. It was also important that the midwife would understand this desire. “*I needed someone who would just ‘get’ me*” (Eibhlin).

Arlene:

... because I knew whoever is home birthing is going to be the same mindset as me. Like it goes without saying if you are a home birth midwife it's because you believe in home births and you think it's the right thing to do and all that goes hand in hand with breastfeeding and attachment and all that kind of stuff. I just felt like they'd be, no matter who it was they'd be on the same page as me.

During all stages of this study I had the opportunity to see and hear women talk of their experiences concerning their relationship with ‘their’ SECM. The significance of this relationship plays out regardless of actual place of birth and has a huge influence on women’s experiences of in-labour transfer to hospital. ^{Fieldnote 2}

▪ **‘It wasn’t just the birth at home, I wanted all that came with it’**

Several advantages in relation to home birth were highlighted by the women and were compared to their perceptions of birth in hospital. For example, statements such as “*more natural*”, “*in your own time*”, “*no interference*”, “*better for your family*”, “*better for your baby*”, “*better for bonding*” were provided by all the women planning a home birth. This study focused on the time of labour and birth but many of the women were at pains to tell me that home birth was not just about birth. It was about a way of life, a belief about pregnancy and childbirth, a space in which care was offered in a specific way. This care was considered to be personal, genuinely woman-centred

(beyond the rhetoric), and truly tailored to meet the needs of women during all stages of their experience.

Eibhlin and Bridget (SECM), (observation):

We were in the house nearly 2 hours when Bridget asked Eibhlin if she could do 'her bits' – testing of urine, BP and an abdominal palpation. Looking on what amazed me most about this – was the time ... all at a gentle pace, nothing was rushed. Eibhlin told me afterwards that this was her favourite part of the antenatal visits, the time when the "wise hands read of her pregnancy and baby what they needed to know". Eibhlin looked eagerly at the midwife, asking- has he grown, what can you feel now, where is he lying? And together they worked their way around her tummy seeking the information.

This was one of the longest antenatal visits I have observed. We were in the house for over 3½ hours. Everything was discussed, everything was explained, and all possibilities in relation to birth were explored. After we left as we walked down the path I asked Bridget about it "Exhausting", she said, but "that's what these women sign up for, that's what they want, that's what they expect, that's what we give." That, it seems, is home birth.

The women suggested that they were not able to access such a system of holistic care within the current organisation of maternity hospitals in Ireland. This was a point that was also raised by the healthcare professionals, but sometimes for different reasons. The SECMs and over half of the hospital-based midwives⁽ⁿ⁼¹²⁾ viewed the continuity associated with home birth as the manner in which care should be organised, regardless of location: "*it's⁴³ the way care should be, if I'm being honest, that is, the kinda care I want all women to have, those in hospitals too*" (Mona, HMW). Other HMWs⁽ⁿ⁼⁵⁾ (and the obstetricians) suggested that such care, during the current economic climate, was a luxury that was not sustainable: "*I wish we all had that time to give, but it is not possible, we are too busy*" (Piala, HMW). The obstetricians appeared to assume that such intense care was not economically viable given the small percentage of women who plan home births in Ireland. They suggested that the low figure was reflective of women's choices, and did not consider the possibility that it related to the ability to secure (or not secure) a home birth. Hospital-based

⁴³ The holistic care provided by a known midwife

staff, in their interview raised their concerns about the “*bubble of care*” home birth provides and how this contributed to disappointment when women had to enter the “*real world*” at the time of in-labour transfer (Sheena, obstetrician).^{Fieldnote 3}

7.2.1.2 ‘I did not want a hospital birth’

The motivation for planning a home birth lay in the belief that this model would offer an experience that would contrast to the routines of birth in hospital. The women who participated in this study and had prior experiences of care and birth in hospitals drew from their own experiences. Others derived their perceptions from the stories of women in their family or their social circle. National groups that provide support for women during pregnancy, childbirth and parenting (e.g. Cuidiú, AIMS Ireland) also provided some of the women with information about the maternity services (e.g. *Consumer Guide to Maternity Services in Ireland*, Cuidiú (2011), which informed their opinions. During the latter stages of field work, women also made reference to the emerging media reports, safety reviews of specific incidents in HSE maternity units and inquest reports that highlighted substandard care or areas of the service that required immediate and urgent review. Women⁽ⁿ⁼³⁴⁾ began to question the safety of maternity hospitals in Ireland. This reconfiguration of safety played out in the women’s suggestions that birth in hospital and the support of obstetricians were not needed for women experiencing a normal physiological pregnancy. This contrasts greatly with the views expressed by healthcare professionals that the women encountered during their pregnancies.

▪ ‘Doctors have no role in normal birth’

Obstetric-led, hospital-based maternity care was the model of care most accessible to the women in this study, but was not considered an appropriate option. This was linked to their belief that pregnancy is not an illness. I observed several discussions between women and SECMs that highlighted clearly the women’s point of view on the role of obstetricians.

Cara and Caoimhe (SECM), (observation):

Cara was filling Caoimhe in on a conversation that she had the previous day with a friend, a friend who did not understand her choice in relation to home birth or why she didn't just get a consultant. Cara very definitely told her "I don't need a doctor, I am not sick".

Other women were more vociferous in denying the place of obstetricians and their role within the maternity services in Ireland.

Gilda:

Doctors have no role in 'normal'. They don't, Linda. They just come in and make it all complicated when it was fine in the first place. They are not needed when there are no problems.

Availing of the services of a maternity hospital in Ireland was associated with obstetric-led care; most of the women⁽ⁿ⁼³⁴⁾ did not consider that alternative options existed within the hospital-based provision of maternity care.⁴⁴ Therefore engaging with hospital care, for these women, meant that they would be "*subjected to obstetric management*" (Gilda) of their care.

Lana and Bridget (SECM), (observation):

Lana started explaining, in her experiences, what the local maternity hospital offered. She suggested that "the doctors there just call the shots", it didn't seem to matter if you were experiencing a normal pregnancy and labour, Lana believed that "your care will be on their terms" and defined by them, not by your needs ... A lengthy discussion was had in relation to the role of midwives and how hard (in Lana's experience) some of them try but really it doesn't make much difference because "at the end of the day, the doctor is the boss".

While all the women who participated in this study disputed the role that obstetrics had in normal, physiological birth, those who had prior experiences of the maternity services highlighted a perception that they had no choice in relation to the model of care that hospitals had to offer. The

⁴⁴ During the course of fieldwork for this study, the requirements of the MOU between the SECMS and the HSE meant that all women who planned a home birth were experiencing a 'low risk' pregnancy as defined by the HSE criteria (Appendix 1). Therefore, these women would have met the criteria to attend midwife-led clinics and DOMINO teams as offered by some of the hospitals in Ireland. Yet, with the exception of a midwife-led model of care supporting home birth offered by one of the maternity hospitals, the women who participated in this study viewed all care offered by hospitals as obstetric-led.

women believed that they would automatically be subjected to the routines of medicalisation of birth. Many did not believe that midwife-led care could exist within the current culture and organisation of maternity care in hospitals in Ireland. ^{Diary Entry 4}

▪ **‘I am afraid of what will happen in hospital’**

Some of the women spoke of specific and personal worries in relation to hospital. Cora spoke of her fear of illness, of “catching something from all those sick people coughing and spluttering around me”; Clodagh spoke of her dislike of needles and her fear that this was something that she would be exposed to; Maireád highlighted her concern that the hospital staff would judge her just because she wanted something different for her birth, something that she considered would not be normal in a hospital setting.

Maireád and Bridget (SECM), (observation):

Maireád talked of wanting to move about during labour. Not just moving, but swaying and swishing around the place. She hoped that this would help her during her experience of labour. She laughed as she showed Bridget and me the actions she had been practising (akin to a belly dance with a pregnant abdomen!). She told me that this was another reason why she did not want to go into hospital, “I’m afraid they wouldn’t let me do this, that they would think me weird and I would end up tied to a bed”. An antenatal visit where woman, midwife and researcher all moved around a kitchen table swinging their hips as they went and laughing at the sight of themselves!

Eibhlin was afraid she would not be listened to, that routine would take over and no-one would be there for her.

All the women raised concerns about unnecessary interventions during birth. They spoke at length of the medicalisation of birth and the impact that they perceived this to have on physiological birth. As with other themes that emerged from the data, the women’s levels of knowledge varied; some quoted anecdotal tales and while others critiqued specific elements of active management of labour and the rising rates of caesarean sections in Ireland.

Norah:

I don't want any intervention, I don't want internal monitors, I want to do it normally, as much as possible, and if it's really needed then intervene but not just straight in there. But I'm afraid that won't be the way it is in hospital, if I go in there all of that will go out the window.

Gilda:

I suppose I come from a sort of a left wing, feminist perspective and I didn't like the medicalisation of childbirth and I knew that we had more consultants in this country than the average and we're much more likely to have caesareans ... I was a bit afraid I would end up having a caesarean section.

Regardless of their sources of knowledge, the women who participated in this study felt that the lines between necessary and routine interventions during labour and birth had become blurred; they therefore worried that any engagement with the maternity hospitals would render them helplessly subject to the custom of intervention they understood to be part of the provision of care. As with the other reasons offered for planning a home birth, concern about unnecessary intervention is threaded through their personal narratives and emerges as an influence on their experiences and interactions at the interface of home and hospital care (Section 8.10). What constitutes a necessary or an unnecessary intervention for the participants of this study again highlights ideologies influenced by perceptions of risk and safety.

The women (excluding those with background knowledge of healthcare professionals ⁽ⁿ⁼⁹⁾) did not make a distinction between hospital-based midwives and doctors at this point. While the medicalisation of birth is traditionally associated with obstetricians (Murphy-Lawless 1998), the women who participated in this study made it clear, during their pregnancy, that they believed that the different ideologies of birth existed in the discourses of the hospital-based staff (meaning the midwives and obstetricians) and the SECMs. They did not consider the role of hospital-based midwives in promoting physiological birth.

▪ ‘ **THEY will just tell me what to do** ’

Reference has been made to the value the women placed on their ability to control the birthing environment when it was part of ‘their space’. They were also influenced by a sense that their individual needs would not be taken into consideration and they would “*not be in control*” (Brid) if they birthed in hospital. For some of the women⁽ⁿ⁼¹⁶⁾ (e.g. Geraldine, Eibhlin, Riona, Nessa, Maura), this belief arose from previous encounters with the staff of maternity hospitals. Other women based their opinions on stories and experiences they had heard from women and from encounters with other healthcare professionals (in other aspects of their lives).

Maura and Cliodhna (SECM), (observation):

During the booking visit with Cliodhna, Maura referenced frequently her previous experiences. She was amazed how different this was. She highlighted that if she was opting for hospital-based care that it would be a very different experience – “I would have to just toe the line, do what I was told and fit in with them and whatever was going on”.

The women did not suggest that all HMWs would take control. But all were concerned because that they did not know who they would meet if they engaged with the hospital system, given the way that the midwives organise their work around shifts rather than a caseload practice. As a result women felt that their experience in hospital could be unpredictable and influenced by a roster. This was a chance that some of the women were not willing to take.

Blaithin:

I think it all came down to trust, you know ... how can I trust them when I don't know them? ... you don't know who's going to be delivering you,... it's a scary thing to get into a situation where you're dependent on people who you don't know, you don't know anything about the way they think, ... and they are calling the shots.

Aoife:

... it's all so ad hoc isn't it, like you can be so lucky and you can meet a good midwife who will help you and support you, and then you can just meet another one and it's her way or the

high way and you are on a monitor before you know what is happening ...

There was a perception that the HMWs were in such a position of influence that they had the power to determine the women's experiences. The women viewed these midwives as gatekeepers to the *management* of labour and suggested that the midwife you met could "*make or break your experience*" (Carys).^{Diary Entry 5}

The expectation that they would be *told what to do* presented a worry for the women in that they were concerned that they would not be in position to disagree with the healthcare professionals. The women⁽ⁿ⁼²⁵⁾ were concerned that, in this situation, they would agree to care that was not part of their birth plan.

Arelene:

I don't know how I'm going to act in birth, in labour, and I could be easily swayed I'd imagine into having an epidural, having a c-section, having forceps, even though I didn't want any of those things, you don't know. You are so vulnerable and I was worried about these things, that they would start talking about them because they didn't know what I wanted, what my plan was and I wouldn't be able to say no.

Having a home birth was seen as way to avoid an encounter with an unknown midwife and a way for the women to decide who would support them during birth, a way to avoid someone who would not acknowledge their specific needs. These perceptions were of inherent problems linked to not being known within a large institution and were compounded by the routines of care associated with maternity hospitals in Ireland.⁴⁵

⁴⁵ It is worth noting that many of the women relied on engaging whichever SECM was free to offer them support and so it was in a sense a random selection. Not all women were supported by their "*first choice SECM*" (Brid). However, as I noted in my observations, the women spoke of their shared philosophical position in relation to birth; they viewed this as a good starting point for their relationship. They also identified the lengthy process of getting to know their SECM and vice versa and how this ensured that their birth plans and wishes were discussed during their pregnancy and in advance of labour.

▪ **‘I know what they are like’**

Previous experiences of maternity hospitals and of the care offered by midwives and doctors therein draw together the points which emerged from the category ‘*I did not want a hospital birth*’. The women⁽ⁿ⁼¹⁴⁾ who had birthed previously in hospitals in Ireland or had exposure to the maternity services highlighted their disillusionment with the system and with their experiences.

Eibhlin:

X’s [daughter’s name] birth, it was just so invasive, so rushed. It was a busy day, there were lots of women around and they just wanted me out of there. So they hurried it up as much as they could. I am not having that again.

Geraldine:

... my previous delivery ... it wasn’t managed well at all ... I did not like the woman assigned to me on the day ... I was really terrified that if I went to that hospital that is what it would be – awful, absolutely awful.

Even the women who did not have previous negative personal experiences held a perception of what was possible; these perceptions were grounded in negative and unpleasant tales. They did not want to risk undergoing a similar experience.

Jenniver:

I’ve heard, you know, other women talk of what it was like for them. I don’t want that. I’m one of these people who works best on her own and that is what I want, I don’t want to be to someone else’s schedule.

7.2.1.3 ‘There was no other option available’

A theme to emerge from the data that is not reflected in the literature is the dilemma that some of the women expressed in relation to choice and the limited options of maternity models of care available to them. Eight women in this study had originally planned a home birth not because they wanted to birth at home *per se*, but because they felt the alternative would not give them what they wanted. Home birth was the default position. ^{Fieldnote 6}

Doireann pointed to a specific gap in the provision of maternity care in Ireland. A number of the women in this study planned to labour and birth in water as part of their home birth experience. However, Doireann said that it was her wish to birth in water that led her to home birth. (Since May 2014 one hospital in Ireland, the Coombe Women and Infants University Hospital, supports women who wish to have a water birth.) As highlighted in Chapter 4, the option of midwife-led care is not available in all geographical locations; there are just two midwife-led units in the country (both of which provide birthing pools for pain relief in labour only). For Tara and Olwyn, a midwife-led unit located alongside or near a hospital was their first choice, but geographically this was not a feasible option.

Olwyn and Caoimhe (SECM), (observation):

During the course of this antenatal visit Caoimhe asked Olwyn to tell me why she had decided on a home birth, her reply [was] “there was nothing else for me” ... she didn’t want a home birth (initially) but she really didn’t want to engage with the local maternity hospital. What Olwyn wanted was a birth centre; she described this as “the best of all worlds”. When this was not available to her she planned a home birth as her second option.

Tara and Cliodhna (SECM), (observation):

Tara knew of my study and was full of questions when I got there. She initiated a discussion in relation to the options that women in this area have. She stated that a birthing centre, a midwife-led unit, would be the best option in her view, “you know, you can have midwives, no interventions, but then you are in the hospital if you need to be, like in England”.

All the women made reference to other jurisdictions, where they suggested that more options were available and that midwife-led care within a hospital setting genuinely meant midwife-led care.⁴⁶

Home birth was perceived, by the women who participated in this study, to be an appropriate choice that they considered to meet their specific needs and therefore to provide them with a safe option in relation to place of birth.

⁴⁶ As previously mentioned, the option of midwife-led care within a maternity hospital in Ireland was viewed with suspicion and disbelief. Maternity hospitals were associated with varying adherence to the elements of active management and with obstetrically managed care.

The women indicated that this view contrasted with the opinions of many healthcare professionals they encountered during pregnancy and indeed during birth. ^{Diary Entry 7}

7.3 Healthcare Professionals' Views of Home Birth

The views about birth of the healthcare practitioners in this study varied both within and across professional groupings. These variations were influenced by their personal philosophy and by different professional experiences, and were informed by discourses of safety and risk.

In sharing their experiences of in-labour transfer, the healthcare professionals who participated in this study also offered insights into their perceptions of home birth. While some overlapping themes were observed and recalled among the midwives (HMWs and SECMs), the obstetricians showed significant differences in their views. Analysing the healthcare professionals' different readings of birth, and the different background experiences that informed their viewpoint, facilitated my understanding of the cultural context in which their experiences of in-labour transfer occurred. ^{Diary Entry 8}

The participants of this study fell into distinct groups in relation to home birth. The groups were divided into those who supported home birth and those who supported home birth but applied conditions to this support. No participant suggested that they were against home birth or thought that it should not be allowed, as is the case in other jurisdictions (e.g. Chervenak et al 2013). However, there were diverse views about the regulation of home birth and the supervision of those who facilitate birth outside hospital.

7.3.1 'Yes, of course I support home birth'

Unsurprisingly, the theme '*Yes, of course I support home birth*' emerged from interviews with the SECMs. It is important to acknowledge why they supported home birth. As noted in Chapter 6, the SECMs came from diverse personal and professional backgrounds. Some practised solely in the community while others divided their time between their role as an SECM and other midwifery positions. A number of the SECMs had been educated

or had practised midwifery in other jurisdictions and had been exposed to various models of midwife-led care. Their role as an SECM stemmed from these prior experiences; they had seen birth at home and had been exposed to midwife-led models of care. The SECMs spoke of the benefits of these models of maternity care – for women, for midwives and for birth.

Caoimhe and Enora made it clear that they liked the opportunity to support natural, physiological birth. They suggested that women who choose home birth are focused on normal birth and that supporting them was, for some of the SECMs, what being a midwife is all about. The numerous diary entries I made during fieldwork highlight that this was something that resonated with me, with the midwife that I am. However, the steps of VCRM and the reflexivity inherent in this ethnography ensured that I was sensitive to this and that I did not elevate home birth on to a pedestal at the expense of other models of maternity care and the experiences therein. ^{Diary Entry 9}

Niamh's home birth with Bridget (SECM), (diary entry):

I sat, I watched, I listened and I remembered. I remembered this feeling. The excitement coupled with a heightened awareness of every noise, every movement, every gasp this woman made. Followed by exhilaration, the joyous sight and sound of a newborn baby. The taste of salty tears as laughing and crying were part of one emotion. In this moment, I remembered this feeling and what it was to be a midwife.

I read [the above] passage to Bridget; she teased and called me a 'home birth newbie', later she said "I suppose you have to get those feelings, otherwise why would you continue to do it"?

Some SECMs⁽ⁿ⁼¹²⁾ stated that they facilitated home births because they liked the way care was organised.

Riona and Leah (SECM), (field notes):

After the visit with Riona, Leah and I chatted outside her house. Leah talked of home birth, why she is a SECM. She talked of her experiences of really getting to know the women and therefore felt she could begin to understand what they

want. In her experiences something just felt 'right' about organising care this way.

Caoimhe (SECM):

I get a buzz out of it. Birth is just my thing and to be able to be there, with these women, the whole time, and be their midwife. Now that is just amazing.

Practising as an SECM, facilitating care during home birth, was for some of the midwives a way to remain connected with midwifery and with normal birth. Some of the SECMs who had recent professional experiences within other aspects of the maternity services spoke of their disillusionment with the system, their frustrations with the quality of care, their despair with the increasing rates of intervention. Supporting home birth was a way to “*feel like a true midwife*” (Naoise), a way to “*remind me what it is all about and how birth can be*” (Maeve), a way to remember to “*wait patiently, yet attentively for birth*” (Siofra); “*home birth is what keeps me sane*” (Janet). During the course of fieldwork and my observation of the care offered by SECMs and their interactions with women during labour and birth⁽ⁿ⁼¹⁰⁾ I saw *how birth can be, I saw how midwifery can be.*⁴⁷

In spite of all the positive aspects these midwives recalled concerning home birth and community midwifery, being an SECM was not without its challenges. The challenges the SECMs most frequently referred to related to the place of home birth and of SECMs within the organisation of birth in Ireland.^{Fieldnote 10}

Home birth was not viewed as the only model for birth. Regardless of their critique of the maternity services, all the SECMs who participated in this study spoke of the important role that hospital-based, obstetric-led care played in the care of some women. All identified experiences in their professional careers when they had relied on, and were thankful for, the presence of hospitals and hospital-based staff. These midwives suggested

⁴⁷ I have included some of my field notes and diary entries throughout the text and in Appendix 2 in order to integrate my reflections on the experiences I was exposed to and go some way to being transparent in relation to the impact that the fieldwork had on the midwife and the researcher that I am.

that there was no place for “cowboy midwifery”⁴⁸ (Enya), for “mavericks out there doing their own thing and giving the rest of us bad press” (Maeve).

Bridget (SECM):

It shouldn't be home at one end of the scale and then hospital at the other end. It should be home and hospital and everything in-between, mixed and matched as the women need and want it.

Eimear (SECM):

It's not home birth at all costs you know, and that needs to be clear with everyone. There are times when home is not the best place to be, and you know, that is when we need to do something and transfer, we need to be big enough to get other people involved. Everyone wants the same thing at the end of the day; maybe we just have different ways of going about it.

All the SECMs who participated in this study highlighted that they saw a distinct difference between normal birth and birth that needs obstetric support. However, as the interactions (my observations and participants' recall) between healthcare practitioners demonstrated, it was the definition of *normal* that was often the source of contention, this contention being fuelled by understandings of risk (see 8.7.2).

Although the SECMs acknowledged the role of hospital-based care, they identified that one of the greatest challenges they face is the belief, held in their opinion by many hospital-based practitioners, that one model of care is appropriate for all women (see 8.7.2.2).

7.3.2 'I support home birth but...'

Data from the interviews with the hospital-based midwives and obstetricians provided an insight into their views of home birth. The participants suggested that they supported home birth, but the support was offered with conditions and subtext. Many of the sentences led with “*I support home birth*” followed by “*but ...*”. Discourses of risk and safety

⁴⁸ To ensure my understanding of Eimear's phrase reflected her intentions, I contacted her when I was analysing her interview. Eimear suggested that ‘cowboy’ related to “reckless, unreliable, shoddy work”, or practice that was not considered to be in line with the appropriate evidence.

were revealed in these caveats. These constructions of risk also underpin the interface of home and hospital birth (Section 8.7).

A lack of exposure to home birth was highlighted by nearly all of the HMWs (n=14). Some had limited experiences of home birth and other midwife-led models of care during their midwifery education and midwifery experience in other jurisdictions. However, the midwives suggested that the provision of maternity care in Ireland did not lend itself to an integrated service between home and hospital.

Shíona (HMW):

I am grand with home birth; more of them needed around here is what I think. You know when I worked in England, well it just was the normal, it wasn't everyone having a home birth, but it was just ... no one made a fuss, everyone just got on with it and the midwives were part of the hospital team and everyone was fine. But it's a bit different here in fairness, everyone is, well so separate and it's like those midwives are from a different planet ... not for me, but for some midwives, you know yourself, those who haven't seen anything but this place. I think home birth is great but I don't think the overall supports are here for it.

Mona (HMW):

I sat in class listening to them going on about normal, I was here doing my training, we were hearing about woman-centred and ... that it's normal and blah, blah, blah, then the next day we were in an obstetric-led unit ... we're a million miles away from community midwifery. We're so institutionalised, we're so focused on CTGs and things like that, safeguarding ourselves and having someone else that the buck stops at rather than the buck stopping at you. So I suppose I have a personal curiosity about it all but you, know no practical experience really.

The obstetricians also recalled experiences of working in healthcare systems where home birth was more common. They too spoke of the infrastructure in Ireland, the current provision of maternity care and their views that “*it's much more difficult here; the structures just are not there*” (Brenda, Obs). There was a sense of this being a justification for the current organisation of services rather than a challenge to overcome.

This lack of exposure to home birth was coupled with anecdotes that put home birth in a negative light. This point will be advanced in Chapter 8 where HMWs and doctors said that they rarely heard of positive home birth stories. ^{Diary Entry 11}

Eileen (Obs):

The ones [home births] that stand out in my mind would be ones where they would have more negative connotations than positive, because I suppose by their nature, when patients are transferred from a home situation into hospital, they are transferred in because there is an issue. It's a bit like, you know, women have a bad experience with home, you know there are not many of them, but we tend to see the ones who do we don't see the thousands that don't have a negative experience. So I suppose your opinion is probably slightly coloured by that.

This was a perception that they brought to their experiences of in-labour transfer; home births were associated with dramatic or poor outcomes. They made this assumption when they heard that “*a home birth was coming in*” (Piala, HMW), assuming that the outcome was going to be bad. Regardless of a phone handover the midwives may have received, they spoke of the dread they felt while waiting for the woman to arrive. The hesitant support for home birth plays out in the interactions between women and healthcare professionals during women’s periods of antenatal care and at the time of transfer. As is evident from their experiences at the time of transfer, women interpret this uncertainty as lack of support for their decisions not only in relation to place of birth but also regarding their choices for birth.⁴⁹

7.3.3 ‘I am not against home birth but ...’

When disclosing their views in relation to home birth, all participants of this study suggested that they were broadly in favour of birth outside hospital, but some of the hospital-based professionals took the more negative stance of ‘*I am not against home birth but ...*’.

For the most part these participants spoke of their perceptions in relation to the regulation of home births and the practice of SECMs. The obstetricians focused on governance structures and the processes of supervision that they

⁴⁹ E.g. in relation to analgesia, augmentation of labour, wish to avoid an instrumental birth.

felt should be in place. HMWs⁽ⁿ⁼¹²⁾ made reference to local guidelines and policies and how these should guide the SECMs' practice. Both participant groups highlighted that "tighter controls" (Sheena, Obs) were needed when identifying who could or could not have a home birth.

Sheena (Obs):

There is nothing wrong with home birth, I don't have an issue with it, but it needs to be regulated properly. The criteria need to be tighter, regulations need to be tighter, for the women who are having the home birth in the first place and then for the management of care.

These views were held at a time when, according to SECMs, their practice is closely regulated and monitored due to the governance structures within the MOU (Section 8.4.3). Criteria devised by the HSE stipulate who can or cannot avail of a home birth, and the criteria by which labour is deemed to be outside the terms of the MOU and therefore transfer to obstetric-led care is required (Appendix 1). Yet this regulation was perceived as lax and not stringent enough by the obstetricians who participated in the study.

The SECMs also raised the issues of governance, supervision and peer support, and expressed frustration that roles are assumed by midwives with little or no experience of home birth or community midwifery services. The obstetricians, however, suggested that home birth and SECMs should be governed by the current maternity hospitals. They proposed that governance structures in place within their organisations should be extended to the community and become the reporting mechanism for the SECMs.

Eileen (Obs):

So it's not a good idea to have people working stand-alone. They need, from a professional development point of view, from a 'keeping current' point of view, from 'working within protocols and guidelines' point of view – there needs to be some sort of oversight, there needs to be a governance structure, and they need to be working with colleagues. And I think the current system doesn't provide for that. So I think, in some way, we need to provide that sort of ongoing oversight training, governance, collegiality, audit, you know all of that needs to be built in to what is going on. I mean if you look at what is clinical, what is clinical governance? Clinical

governance is all about, you know, maintaining high standards, maintaining education, working within guidelines, auditing your practice, all of that. And that needs to be overseen by someone. In my view the people best placed to do that would be the hospital within the region that the midwife works. No one should be there working on their own, not governed.

Reference to supporting the SECMs was not made, rather it was considered necessary to oversee their practice.⁵⁰ The HMWs were less focused on the broader structures of governance and more concerned with their local guidelines.

Alva (HMW):

I don't have a problem with home birth but they [SECM] should follow our guidelines, wouldn't that be helpful for everyone, especially when they have to come in to us.

The unquestioned assumption that the hospital guidelines were based on the *best* evidence was put forward by some of the HMWs. They also suggested that there was no reason that midwives in the community should not embrace them and use them to guide their practice. This thinking was also apparent during the experiences of in-labour transfer when HMWs made reference to the hospital guidelines and questioned any decisions that the SECMs made that were not informed by these guidelines. Guidelines underpinned by a medicalised approach to midwifery care were often used as a reference to assess decisions made by SECMs. The SECMs and women challenged the appropriateness of “*this judgement*” (Enora, SECM) and referred to hospital policies as being informed by “*an obstetric understanding of risk and mechanisms of medical surveillance and control*” (Caoimhe, SECM).

The healthcare practitioners who participated in this study did not articulate an anti-home birth stance, but (except for a small minority) their attitudes often belied their words; in addition, the articulated pro-home birth stance is

⁵⁰ The MOU and its associated governance structures have been in place since 2008, but the obstetricians who participated in this study did not have a clear insight into the framework or believed that it did not go “*far enough to monitor their [SECMs] practice*” (Brenda, Obs).

not reflected in all the experiences recounted by the women participants. Part II of this chapter explores the antenatal interactions that occurred between women and healthcare professionals⁵¹ and highlights the dichotomy between those who support home birth and those who question its appropriateness as a model of maternity care in Ireland. These interactions affect women's perceptions of models of maternity care, their opinions of healthcare professionals, and their expectations of in-labour transfer. ^{Diary Entry 12}

Part II

7.4 The Journey Toward Home Birth

During the course of fieldwork, the stories shared by the women highlighted their journey to home birth within a culture that supports, for the most part, birth in hospital. This journey provides insights into the interactions between women and healthcare practitioners. Apparent in these interactions were perceptions of risk, power and trust, which influenced how women felt that home birth was viewed by the maternity services and their expectations concerning transfer to hospital.

7.4.1 Planning a Home Birth – Finding a Midwife

Challenges associated with organising a home birth in Scotland (e.g. securing a midwife, having their home birth approved by the local health authority) have been highlighted by Edwards (2001); organising a home birth in Ireland is no different in so far as the participants in this study recalled the numerous obstacles they encountered. Eight of the women went to great lengths to secure the support of an SECM. They frequently relied on the goodwill of the midwives to help them with this process, while, in their experience, the HSE information in relation to the National Home Birth Service did not provide enough detail on the intricacies of navigating the journey to finding an SECM.

⁵¹ The experiences highlighted by women were not focused solely on interactions with healthcare practitioners who were participants of this study.

Blaithin:

I called basically all the independent midwives that I could and they were all booked up because you have to call them while you're having sex, to make sure you book in. So Caoimhe had just started practising as an independent midwife ... somebody I was in contact with told me 'oh I heard that there's a new midwife starting practice, try contacting her'. So that's how we ended up together.

Arlene:

I got pregnant, waited twelve weeks, big mistake, to ring. I didn't realise that there would be an issue or a problem ... I had rung everybody twice and there was a couple of midwives who were trying to take me ... so I was waiting for them to return calls. I never gave up ...

Due to the small numbers of SECMs in Ireland and their sporadic geographical location, women frequently recalled phoning and re-phoning midwives until they found one in a position to support them. Arlene, Gilda and Bríd asked the midwives to put them on a 'waiting list' and to contact them if any women chose not to have a home birth or had to transfer to obstetric care antenatally. It seemed as if there was a reserve list where women held out hope that they would find an SECM prior to labour and birth. Gilda likened herself to a vulture hoping for a spot to become available, while at the same time being acutely aware that this meant that for some reason another woman was not having her planned home birth.

Norah and Gwen considered themselves lucky; someone told them that a new midwife had just signed an MOU so they found her quickly in the hope that she would support them. Geraldine, Alannah and Ríona knew the SECM through their social circle, and therefore felt that this was a positive factor in their ability to secure an SECM. Cara, Lana, Cait and Niamh were supported by the SECM who had supported them during previous pregnancies. All the SECMs said that they would do anything to make it possible to support "recurring women". However, given the number of women seeking a home birth and the fluctuating number of SECMs, this was not always possible.

This somewhat random process meant that some women were not supported by an SECM of their choosing but by whichever SECM they could get.

Arlene:

Well, my first choice for a midwife would have been X [SECM name], because I know her, my family know her, my sister had her. When she couldn't take me I went looking for someone else and found X [SECM name]. ... I was just happy that someone was willing to take me on.

Brid:

I didn't know her, but sure I just thought that didn't matter I suppose ... I mean the fact that she was doing home birth meant that she had to be on the same page as me.

The women who did not have prior exposure to the maternity services and those who were planning a home birth⁽ⁿ⁼²⁸⁾ for the first time expressed surprise at their experience of seeking an SECM. It was felt that the HSE advertisement of a National Home Birth Scheme was misleading in that an SECM was not available for all women, nor was the local health service under a legal obligation to provide a midwife to facilitate the women's choice of home birth. Those who had some exposure to other healthcare systems (e.g. the National Health Service, UK) were amazed. Many women suggested that a lack of support for home birth at the organisational level of the health services seemed to them a sign that the HSE did not value out-of-hospital birth.

The SECMs who participated in this study were very aware of the challenges associated with finding a midwife. Many spoke of experiences that echo the entry in my reflective diary.^{Diary Entry 13} Once the name of an SECM was in the public domain, the SECM was inundated with phone calls from women. Even when the SECMs were on leave (e.g. maternity leave, sick leave); the phone enquiries did not stop, as women did the rounds of all possible options.⁵² The SECMs expressed frustration about this, and in

⁵² During the life of this study, I was phoned by five women as they tried to secure the support of an SECM

particular about the organisation of maternity care and the fact that, they felt unable to support all the women who contacted them.⁵³

Rosa (SECM):

I feel so bad. These women, you know, they phone me and at the start of the conversation they sound so hopeful, they want to have a home birth, they are giddy with the idea of it. And then I tell them that I can't take them on and they are just gutted. One woman started crying the other day, it was so awful, but what could I do? I had other women booked, I couldn't take her on. I told her to phone the HSE to see if she could put her in contact with a midwife, but sure I was only clutching at straws there because in my heart I know all the SECMs are full that month. I felt so guilty like it was my fault that she couldn't have her home birth.

Ciara (SECM):

This woman kept phoning me, I don't know how many phone calls I got from her – maybe 5, maybe more. She just kept hoping that I'd change my mind ... but I couldn't. I don't know what I said that she saw a sign that I'd suddenly say 'yes' but God love her she just wouldn't give up. In the end she was getting a bit cross with me, you know, she was not happy. Now I know it wasn't personal or anything but it was not a nice situation to be in.

While frustrated about the scarcity of SECMs, these midwives could understand how such a situation arose. Those who also practised in a hospital setting tried to recruit some of their colleagues; this led to some success in providing midwives to support the primary SECMs with a caseload. However, the SECMs expressed an understanding about the reluctance of most hospital midwives to facilitate home births, and blamed the lack of supports for community midwives for this.⁵⁴ The fieldwork for this study was completed prior to the requirement of the amended MOU (Appendix 1) that two SECMs must be present at a home birth (March 2014); therefore, the experiences of women and of SECMs in light of the challenges that this stipulation entails warrant attention in future studies.

⁵³ At the time of writing, the SECMs had begun to compile a database on the number of women they had 'turned away' over a calendar year.

⁵⁴ See OBoyle (2013) who addresses the professional isolation experienced by SECMs in Ireland and the challenges that this presents to autonomous midwifery practice and to home birth.

These experiences of searching for an SECM and the lack of HSE supports were viewed in a similar manner to the interactions with GPs (Appendix 9), in that the women suggested that planning a home birth was an “*awkward choice*” (Gilda), which the HSE and some healthcare professionals were not in support of. As a result of this, the women indicated that they had developed a strong connection to anyone who did support or in any way facilitated their home birth.

7.5 Discussions of Risk

As explored in Chapter 4, any discourse of safety and risk is located in a specific historical and social context. Chapter 4 references some of the events in the early part of the second decade of the 21st century that influenced women’s constructions of safety and risk in maternity care. The safety of maternity hospitals, which had been revered and held as responsible for the decrease in mortality of the early 20th century was now questioned by key stakeholders (women and healthcare professionals) (Murphy-Lawless 2011). Others, as is evident in the narratives of some of the hospital-based practitioners of this study, still hold the belief that hospital is the safest place for birth, maintaining that hospital, with its technological supports and obstetric expertise, is necessary to safeguard against any uncertainty. The dichotomy between these ideologies was apparent in the women’s interactions with hospital-based healthcare professionals. These antenatal engagements and the experiences of women therein reinforced women’s perceptions of hospital-based maternity care and served to isolate them further from those who held a different understanding of birth.

The fieldwork was carried out at a time when all women planning a home birth also booked with their local maternity hospital. Many accessed the screening options that the hospital had to offer (e.g. blood tests, ultrasound scans). Others engaged with the hospital following a referral from their SECM during pregnancy (e.g. Doireann for assessment of liquor volume; Eibhlin to ascertain the presentation of the fetus; Síle for assessment of fetal wellbeing at 41 weeks’ gestation). The interactions during these encounters and specifically those that were labelled as “*unpleasant*” or

“*confrontational*” influenced women’s perceptions of the care they would receive in hospital or the way they would be treated should in-labour transfer occur.

7.5.1 ‘You’re brave’

The word ‘brave’ featured time and again in the women’s narratives as they recalled their encounters with hospital-based midwives. The context in which this word was used is important. Some women perceived it as encouragement:

Siabh and Leah (SECM), (observation):

Siabh spoke about the booking visit at the hospital. She told us that she met a midwife that was very encouraging and enthusiastic. She [the midwife] told her that she was great, that she didn’t know if she would be that brave and would dare try and manage without an epidural. The positive affirmation offered by the SECM mirrored Siabh’s interpretation of the comment.

For others, the term was offered with a disapproving tone:

Maireád:

And so the midwife was doing the scan and we got talking about stuff and so I told her that I was going to have a home birth. She looked a bit horrified to be honest and said “you are brave aren’t you, I don’t know if I’d do that” and I sounded like I was doing something that was just so off the Richter scale, you know, something that was so irresponsible and dangerous altogether.

I have made previous reference to the fact that on occasions the women who participated in this study made little distinction between hospital-based midwives and doctors; however, in this case the ‘brave’ comments were always associated with HMWs. Exception was taken to this in that women were surprised that midwives would offer such a view on birth and on home birth. Armelle questioned a midwife, practising as a midwife, who had displayed such an opinion:

Armelle:

She was a midwife, she goes "oh I don't know whether I'd risk it" and I said – you being a midwife I think that's, first of all, outrageous for you to say to me and secondly it's, there's no more risk involved ... if you knew what it's all about, there's no risk, it's just as safe as having it in hospital, if anything went wrong you'd be rushed into hospital. I said well, she [the SECM] does monitor me that whole time, do you think I'm there by myself?

Arlene, Ailis, Eibhin, Maura, Aideen and Geraldine recalled interactions with HMWs during which the midwives told them explicitly that they did not agree with their decision to have a home birth. The women suggested that the midwives' reasons for saying this varied from not supporting women having their first baby at home to the time it would take to get to hospital. Repeatedly women⁽ⁿ⁼³⁴⁾ recalled that they had been challenged with such questions as: "*But what will you do if something goes wrong?*" Some of the women⁽ⁿ⁼¹⁵⁾ were confident in their decision and in their belief in physiological birth and home birth, and felt in a position to address the HMW's response. While they felt this to be frustrating or annoying, they did not let the interaction have a negative impact on the choices that they made.

Aideen:

She was like 'well you know we don't recommend ... a home birth ... especially on a first baby'. And I just was able to look at her and go "well that's fine, I don't need you to recommend it."

Nessa and Bridget (SECM), (observation):

Nessa recalled her visit with the hospital last week. She was just having some blood taken when the midwife talked about the risks associated with home birth. Nessa said she just smiled and kept her mouth closed; she wasn't going to let her put her off.

Other women⁽ⁿ⁼¹⁹⁾ found such encounters upsetting and spoke of feeling that their decision was questioned and undermined by the HMWs:

Roisin and Bridget (SECM), (observation):

Roisin is upset when we arrived to her house, she hugs Bridget and starts crying straight away. Bridget had told me before we entered the house to expect this. Roisin described an antenatal encounter with some of the hospital staff. She noted that sometimes they say negative things about home birth and this puts you off them. When she comes away she gets upset. She usually phones Bridget who has to pick up the pieces and reassure her that everything is ok and that she is not a "crazy women making desperate choices".

The experiences of conflict influenced how comfortable women felt in engaging with the maternity services during the remainder of their pregnancy. Where possible they avoided interactions with hospital-based staff and continued their care with the support of their SECM.

Diary Entry 14

7.5.2 'Home birth is risky and dangerous'

The HMWs were not the only ones to show their disapproval of the decisions women made in relation to place of birth. Interactions with obstetricians left some of the women in no doubt as to the lack of regard they held for their out-of-hospital birthing choice. During antenatal encounters with HMWs and junior doctors, senior obstetricians were asked to talk to nearly half of the women⁽ⁿ⁼¹⁹⁾. Comments such as "I'll just get the doctor to talk to you", "I'll just get my boss to have a word with you about that", "I think you need to talk to the doctor" were often offered in response to women's admissions of planning a home birth. This 'talk' was characterised by Geraldine as the 'do you realise conversation' during which "one of the heavies" (Jenniver) gave a catalogue of negative experiences of labour that were held to be associated with home birth. These conversations were described as negative, sometimes aggressive and confrontational, and more often than not upsetting. ^{Fieldnote 15}

Brid:

She [hospital midwife] said "we're not anti home births but we don't support them for first births because you never know how they're going to go". So I'm sitting there just swinging my legs like a little child going, don't let this phase you, don't let this phase you. And she goes "I'll just get the main doctor to talk to

you". So she went out and I was just praying, going "please don't let me cry, do you know, and break down" ... and he [obstetrician] was like "we support home births for second labours but what has your midwife planned if you have post-partum haemorrhage, how is she gonna detect fetal distress?", da, da, da, and I answered as well as I could and then of course a second main doctor came in and said the same thing ...

Cora:

We had said we were considering a home birth, and he was dead set against it, we had a huge argument with the doctor ... I came out and I was so upset, I was crying, I held it together while I was in there, but he was just very aggressive ... very anti home birth, said that if we were going down that line that we weren't to come back to the hospital, that we were to have nothing to do with them and that he was writing it on our chart to make sure that everybody knew. So I got a copy of the chart back and it was ... "is looking for homebirth, we've told her that she's not, not to attend here" and all this sort of stuff ... it was very negative and it was, it was a horrible experience.

Ailis:

When I went in to my consultant appointment at the hospital, and I said "oh I'm thinking about having a home birth" like I wasn't thinking about it, I was having one, but I was trying to word it. And he said "oh, you know your baby will die, your baby will be floppy, the baby won't breathe" ... And I said "well, there will be resuscitation equipment there, so the baby will be resuscitated" you know. Everything he said, I had enough knowledge to know that could happen at home, that could happen in a hospital ...

It must be noted that these interactions were between healthcare professionals and women who did not have any 'risk factors' whereby the HSE would deem them unsuitable for a home birth. This cohort of women was not in a position where they had to argue their case so that they would be considered eligible for a home birth. Yet they had to remain determined and steadfast in order to justify their choice. Gilda and Eibhlin asked for the evidence underpinning some of the points that were being quoted to them, given that they were experiencing a 'low risk' pregnancy; frequently explanations were offered that they deemed to be based on anecdote.

Eibhlin and Bridget (SECM), (observation):

The doctor in the hospital just kept saying to her “but you never know what will happen”, he kept talking about risks, saying that risks were associated with birth and they could happen very quickly. When Eibhlin asked him about the risks associated with hospital she felt it threw him slightly, and kept going back to telling her what she interpreted to be his opinion. From my observations of the interactions between Eibhlin and Bridget, Eibhlin appeared to have a respect for the way the SECM answered her questions, even the answers that she did not like (e.g. a discussion re transfer if there was meconium in the liquor).

Síle:

At the end the doctor kept talking a lot about risks, and not knowing what was going on ‘cause I was over my due date... I think he just disagreed with anything that wasn’t the hospital.

The message that the women took from these interactions was the practitioner’s belief that there was an uncertainty associated with birth. With this uncertainty came risks, and hospital was deemed to be the appropriate place in which these risks could be monitored, minimised and contained. The women made clear that their understanding of birth and perceptions of the safety of maternity hospitals were very different. They said that they did not share the unquestioning faith in hospitals demonstrated by some of the healthcare professionals they encountered. Some of the women (Geraldine, Gilda, Alison, Síle, Jenniver, Orla), were able to express and defend their position and their choices. Others (Arlene, Carys, Laoise), found such situations intimidating and suggested that they were so overwhelmed that they could not find their voice or the will to “stand up to these people” (Carys). It was suggested that these interactions, rather than highlighting negative aspects of home birth, had the effect of strengthening the women’s resolve not to engage with hospital-based care and the practitioners therein. Women⁽ⁿ⁼²⁰⁾ suggested that it “reminded me why I did not want to come here in the first place” (Aideen); “if I had any doubts about having a home birth, that answered them for me, why would you want that kind of treatment” (Ailis); “this is exactly the kind of thing

that I was hoping to avoid” (Arlene); “this is not the way I wanted it to be, that’s why I didn’t want to go anywhere near them” (Sile).

The women in this study were left in no doubt that planning a home birth transgressed the cultural understanding of birth in Ireland that is underpinned by obstetric discourses of safety and risk.

7.5.3 ‘I stopped telling people’

The experiences women recounted of their antenatal interactions had an impact that I had not anticipated. Some of the women⁽ⁿ⁼¹⁵⁾ stopped talking of home birth during their contact with HMWs and obstetricians.⁵⁵ Even the women who had not had negative interactions with hospital staff adopted this strategy.

Ailis:

... an older midwife, she was taking my history, and I said ... “I’m going to have a home birth” and just her whole, like even it did get her back up, like her whole way she spoke to me changed, the whole way she looked at me changed ... she was looking at me like I was crazy and was making all these notes ... in the top of margins, that I know notes don’t go there, do you know? So I stopped talking about it, I didn’t say anything else to her.

Women felt that, because they planned a home birth, their antenatal encounters with hospital-based practitioners challenged the certainty of hospital knowledge and initiated interactions that were described as unpleasant and at times confrontational. Women chose not to talk of home birth as a tactic to subvert the maternity system and to move beyond interactions that questioned their decisions. ^{Fieldnote 16}

Maura:

I met Maura during the third trimester of her pregnancy. ...Talking of her most recent encounter with the hospital, “I just wanted to have my scan and know what way the baby was lying and then to get out of there ... I did not want to have the

⁵⁵ In order to avoid conflict or worry, many of the women (e.g. Cara, Bríd, Rona, Ethna, Ailsa, Mairead, Nessa, Gilda, Maura, Loaise) did not discuss their plans in relation to home birth with members of their family (especially their mothers and mothers-in-law). At present this is outside the remit of my focus but an area that warrants further investigation.

whole 'home birth dangerous' lecture. I just needed some information from them and then needed to move on and back to my midwife."

Ailsa:

We told nobody. Because I didn't want the negatives planted in my psyche... I didn't want that, I didn't need it.

Rona:

Because they wouldn't have been very supportive. They would have thought it would have been very irresponsible I think ... I did not want to have to deal with that.

During fieldwork I observed women and their SECMs attempting to deconstruct these interactions in order to make some sense of how they could relate to the women's plans for home birth. These experiences appeared to add to the women's sense of *them and us*, where hospital-based practitioners (and to a greater extent the obstetricians) were viewed as a negative, anti-home birth presence. Women recalled feelings of hospitals being "*totally against home birth*" (Arlene); as a result they did not consider their views totally significant to their experiences: "*Tell me what would they know about normal birth?*" (Iseabeal). In contrast, all the women held in high esteem the opinions of the SECMs and their understandings of birth and perceptions of safety and risk. These beliefs held during in-labour transfer when women continued to question the rationale underpinning the care offered by the hospital, and needed the support and reassurance of their SECM to "*keep an eye on what they [HMWs and Obs] were doing*" (Rona).

7.6 Moments of Power

Regardless of the knowledge held by women about home birth and awareness of research that supported this, there was a sense that their choice of home birth was not secure and could be contested by those they believed to be in *the* positions of influence in the maternity services. The women perceived that in this situation the power was held by hospital-based staff, specifically obstetricians.

7.6.1 ‘They’ll take away my home birth’

The interactions that women had during pregnancy with hospital-based healthcare practitioners, particularly with obstetricians, were frequently viewed as threatening their home birth, threatening in the sense that the women^(14 of the 23 I met antenatally) believed that obstetricians were in a position to say that they were not suitable for home birth; “*I was so afraid that they would say I wasn’t allowed*” (Ríona). This fear existed during ‘routine’ engagements with the hospital as well as times when the SECMs suggested that a review of a specific aspect of their care with an obstetrician was needed. Although criteria were set down within the MOU highlighting the incidences when the HSE would not support home birth,⁵⁶ the women felt that personal opinion might also be of influence. They feared that biases about place of birth would come into play.

Ailis:

On like my last, my thirty-week visit, I had actually got into such a state that my blood pressure was a bit high, I was so afraid of seeing the negative doctor ... [referring to a previous, negative interaction with an obstetrician in relation to home birth] that I got myself into a state! I was like “oh, if I have high blood pressure, then they’ll take the home birth off me” ...that’s what used to worry me, that it would be taken away, like that they could decide “no”.

Síle:

So there was this query about my age, you know was I too old to have a home birth that bit in the MOU, so my midwife thought that we better just have it checked out, just so we were all covered. And I was a bit cross about this because there was no issue otherwise. But I suppose she just had to make sure that she was covered and wouldn’t get into trouble. So I asked around, I talked to other home birthers to see what doctor should I go to. I didn’t want to just go to someone who would say no straightaway without having any reason, because I heard other women in my [home birth group] say that was it, once they said no then you would be stuck. So I went to [doctor’s name] in [name of hospital] because I heard that [doctor’s name] was just very practical about it all, and once [doctor’s name] saw that I was healthy it was fine, no drama. But the stress of it and having to figure all of that out ...

⁵⁶ And therefore would withdraw the SECM’s indemnity cover, making it impossible for the SECM to provide care within the stipulations of the current Nurses & Midwives Act (Government of Ireland 2011).

Women put strategies in place to avoid a discussion that, they thought, could endanger their home birth. In a similar way to their approach outlined in Section 7.5.3 (“*I stopped telling people*”), they felt that by ‘*not causing a fuss*’ (Eibhlin) they could subvert subtly the authority which they believed obstetricians held in relation to place of birth and ‘allowing’ them to have a home birth.

Sineád:

I don't know what they were on about, some blood test and iron. They gave me such a lecture and told me that I needed to take tablets every day. So I just said grand, sure I knew that [SECM's name] would tell me what I could do to sort it out. You know, I don't take tablets, but I didn't tell them that, I didn't want to get into a row with them. It was just easier to say yes, agree and then get out of there before they started getting heavy with me. I didn't want them to have any reason to say 'no, you can't have a home birth'.

Eibhlin:

... once they said the baby was not breech, I got out of that room as quick as I could. I did not want them to start poking and find another reason to say “sorry but ...” They were not going to take my home birth from me.

The women’s stories highlighted their resistance to the dominant discourse. This covert resistance was considered an acceptable and necessary strategy to keep the doctors “*on side*” (Aideen), thus ensuring women did not risk a confrontational exchange that might jeopardise their home birth.

Although covert resistance was developed by most women, others (e.g. Ríona, Siabh, Geraldine, Gilda, Blaithin, Ethna) planned an approach with their SECM to ensure that they were able to address any issues or concerns that obstetricians raised. These women spoke of the SECMs providing the evidence they needed to refer to and the questions that they needed to ask. Some of the obstetricians’ reactions to women’s knowledge were positive; obstetricians suggested that the women were making a decision that was informed.

Geraldine:

So I had gone in to meet [doctor's name] just as a routine public patient. [SECM's name] and I had worked everything out and I had told the SECM what I was going to say. So I told [doctor's name] the reasons for my decisions and what I knew, and [doctor's name] said "look, I don't support your decision, I would prefer you came in here, but I know you know what the risks and benefits are, you've made an informed decision so I support your right to make that decision."

Riona and Leah (SECM), (observation):

Riona was telling Leah about her most recent encounter with an obstetrician.... Riona highlighted to the doctor all the information she had read and what informed her decision to decline [Group B strep] screening in this pregnancy. ... "I thought the doctor was going to say I had to, 'til I talked about those guidelines you gave me, then he realised I had done some research into it."

The suggestion that women would be prevented from having a home birth without a sound clinical rationale was deemed disingenuous by the doctors who participated in this study. In their interviews, they referred to the HSE guidelines on home birth and their evidence base. The SECMs and women disputed the rationale underpinning some of the recommendations of the HSE, as laid down in the MOU guidelines, and suggested that in some cases room for interpretation allows personal bias to lead care (e.g. Bridget, Caoimhe, Leah, Rosa, Siofra, Naoise, Caitriona, Enora). While this personal bias could emerge from any and all of the participant groups, the obstetricians were understood to be in a more influential position in that they could choose to state that a woman was not eligible for a home birth and thus call into question the validity of the MOU agreement. This theme of doctor-held power is evident in the women's perception of hospital-based care, but was also deemed to affect those who choose not to have a birth in hospital. The perception of obstetrician-held power emerges in women's experiences of in-labour transfer (Section 8.10). Themes of power also play out in the interactions between SECMs and hospital-based midwives and doctors (Section 8.8.4).

The women attended these antenatal 'visits' alone; their SECM did not accompany them. This is surprising given that the SECM was the main

caregiver and the healthcare professional who had an overall picture of the woman's wellbeing and her wishes and plans for pregnancy, labour and birth.⁵⁷

Diary entry:

Sile's pregnancy is now 41 weeks' gestation and she had a review with the local hospital initiated by her SECM. The SECM wrote a letter to the local hospital and Sile presented herself for the appointment. There was no communication from the doctor to the SECM, Sile recalled that the doctor had talked a lot about 'post dates' but she was unsure if this meant she was still 'allowed' a home birth or not? The SECM then tried repeatedly to get to talk to the doctor, with no success. Sile also had a confused understanding in relation to "changing my dates" that did not make sense to the SECM. I found it difficult to follow what was going on, the word risk was being bandied about with no indication of the risks that had been identified. Why weren't they all sitting down and having a clear conversation?

Doireann and Caoimhe (SECM),(observation):

Caoimhe looked at the note from the hospital that the doctor had written in her chart: "the fluid around the baby ... polyhydramnios", Caoimhe read. "Did anyone talk to you about this, tell you what this meant and how it could impact on your homebirth?" Doireann shook her head. No one had informed Caoimhe about this or discussed a plan of care with her, Doireann said she was told to make her next appointment with the hospital but she had no idea of the significance of this.

Examples from my observations highlight the disjointed care experienced by women who participated in this study. Cases of obstetricians issuing instructions for care and 'management' with little input from the SECMs were not uncommon, in spite of the role of the SECM as the identified supporter during pregnancy and childbirth. The data that emerged from the observation of antenatal interactions show the attempts women made to negotiate the interactions with obstetricians, interactions which they perceived as affecting their ability to be 'allowed' to have a home birth. The opinion that the obstetrician held authority is clearly demonstrated, in that women suggested that they had the power to take away their home birth.

⁵⁷ I observed discussions in relation to consultations where SECMs tried to piece together the comments made by hospital-based staff based on the women's interpretations and reactions.

This awareness of power and who holds the power is apparent in the way that the women anticipated in-labour transfer and at the interface between home and hospital birth (Section 8.10.5). These experiences often led women further away from hospitals and the meanings that hospital-based practitioners ascribed to birth.

7.7 Foundations of Trust

In Section 7.6.1 I highlighted that the women held the SECMs and their knowledge in high esteem. Repeatedly, women recalled and I observed the impact that this respect had on the interactions between SECMs and midwives. Women had in their SECM an ally, someone “*on my side*” (Blaithin), someone “*who wants for me what I want for myself*” (Arlene).

Geraldine:

The thing about [SECM's name] and I don't know if it's the same with other midwives, is you just trust her implicitly, it's incredible, she's an amazing woman ... you just trust her implicitly, I can't explain it, she's just the most incredible woman in the world and I knew one hundred and fifty million percent that she was on my side and that I didn't have to worry about anything ... when you're in [name of hospital] or with any other person you feel like you're constantly battling to have the birth that you kind of want, and I just knew I didn't have to do that with [SECM].

From this shared understanding, a trusting relationship^{Fieldnote 17} developed that contributed to the women's expectations for birth and also influenced their interactions with all other healthcare professionals (Section 8.10.3). I will draw out examples which demonstrate this, in how they talked of and planned for the possibility of transfer during antenatal care.

7.7.1 Talk of Transfer

The previous sections of this chapter provide a picture of the context in which in-labour transfer occurred for the participants of this study and gives background to issues that affected their interactions during transfer. It is also necessary to explore the meaning and attention the participants of this study gave to the preparation for and possibility of transfer.

7.7.1.1 'Be prepared'

Reference was made by all the SECMs to the antenatal preparation that they considered fundamental to the care they offered to women planning a home birth. This antenatal preparation included discussions of transfer, "*the whys, the hows and the wheres of transfer, everything, to be honest*" (Leah). The SECMs suggested that preparation for transfer was as important as any other element of care they offered to women; however, it was a discussion with which some were uncomfortable. The midwives displayed mixed feelings as to how best to broach the subject of transfer and how much emphasis to put on it.

The terms of the MOU and the documentation that the HSE required prior to sanctioning a home birth were viewed as means to initiate a conversation about the topic of transfer to hospital- based care.

Caoimhe (SECM):

You can't avoid it, even if you wanted to. It's part of all that stuff you need to talk about during the first meeting, and the HSE highlight all that you need to discuss before they will approve someone for a home birth.

Cora:

... she [SECM] kept saying, but Cora, you know, there are a high percentage of first-time women, first-time labours that do go to hospital, so she said "be prepared".

During their interviews, women who had experienced an in-labour transfer referred to these discussions and questioned the significance that they held at that moment during their antenatal care. It was suggested, especially by the primiparous women, that their focus during this first official meeting with their SECM was on the joys and excitement of this new home birth relationship. Transfer to hospital was, for some of the women, far removed from their thinking at that time.

Maura and Clíodhna (SECM), (observation):

This was Maura's first time meeting the midwife face-to-face, it was all so exciting, she was so thrilled that she was planning a home birth. Clíodhna did go through all the paper work and

the list of 'reasons to transfer' given by the HSE. But there were so many other things to talk about.

Both SECMs and women highlighted that it was difficult to focus on or even consider transfer to hospital so early into the experience of antenatal care.

Clíodhna:

Yeah, this is difficult because I kind of feel this woman hired me because she would like to have a home birth, so my role is to support her, so if I start talking too much about 'transfer' I'm actually going to reflect on her that this [home birth] is not normal, you know.

Rosa:

Of course I have to talk about it [transfer] ... I can't pretend it doesn't happen. And hopefully I do it in such a way that I am realistic without being overly negative ... it is just hard to get that balance. It can be really hard with the first-time mothers 'cause you know you are talking about so many things at this stage in their pregnancy

Data from my field notes show that the level of engagement and depth of discussion in relation to transfer varied across observations. It must be acknowledged that the content and focus of the antenatal visits was guided by the needs of the woman and the specific gestation of her pregnancy, rather than the needs of this study.⁵⁸

All participant groups in this study raised the issue of preparation for transfer. All of the obstetricians and over half of the hospital-based midwives⁽ⁿ⁼¹⁰⁾ suggested that, in their experience, women were not adequately prepared. The issue of preparation emerges from the women's stories and the sense they made of their experiences.

⁵⁸ In Chapter 6, I discuss the fact that 'transfer' was mentioned during all of the observation sessions but was not always the main focus of the interaction. This led me to believe that what I was observing was a genuine display of antenatal interactions rather than a contrived scene for the benefit of the study.

7.7.1.2 'Transfer – yes it was mentioned'

Despite the attention the SECMs believed they had given to preparing women for the possibility of transfer, many of the women^(n=22/26 interviewed) suggested that this possibility had been too abstract to even consider, and that its significance prior to the event was difficult to recognise.

For women⁽ⁿ⁼²⁴⁾ who had previous experience of birth (at home and in hospital), their focus, for the most part, centred on their understanding of normal birth and their techniques to prepare for and protect this.

Cáit and Siofra (SECM), (observation):

Cait talking about a conversation during the last antenatal visit – We talked about it yes, but no I'm not thinking about transfer ... I have enough to do in planning for the home birth. Preparing myself, thinking positive thoughts ... this is not something I can give space to now ... sure all is fine anyway, why would I need to transfer?

Iseabeal and Bridget (SECM), (observation):

I will go wherever this labour will lead me ... but I have prepared for birth ... my body knows what it is doing ... I believe that all will be fine ...

Some women made pragmatic plans in relation to transfer; for example, having a bag packed (Mairead, Jenniver Lana, Ailis), having someone on hand to mind other children (Cara, Nessa, Cáit, Roisin), identifying who would support them in hospital (Carys), having a birth plan that was specific to care in hospital (Geraldine, Aoife, Aoibh, Rona). However, the women highlighted that, while they may have been aware of the possibility of in-labour transfer, it was something that they could not focus on, that they had to direct their thoughts and planning toward the positive expectations of home birth.

7.7.2 'I know my midwife will tell me if I need to transfer'

The discussions of transfer revealed an insight into the relationship between the women and the SECM and demonstrated the regard in which the women held the opinions of the SECM. Time and again the women^(20/23 observations) referred to their belief that the decision to transfer would be completely

guided by the “*midwifery knowledge*” (Ailis) of the SECM. It was suggested that the midwife would know if it was time to transfer, and would identify a reason for transfer; this was “*her call to make, she’s only going to do it if there is a need to*” (Ríona).

Rona:

Bottom line, I knew if it wasn’t good to be at home then [SECM] would tell me and we would just have to go to hospital.

Aoibh:

I had no doubt in my mind ... IF my midwife didn’t like something that was happening and she would just tell me that we had to transfer, no two ways about it ... sure that is why she is here.

All the women talked of trust: they trusted the SECM, they trusted her opinions and how these would guide her decisions. They trusted that transfer would be for a reason, a reason that had their and their baby’s best interests at heart. They trusted the midwives’ skills and midwifery knowledge, and they trusted the decisions they would make. During my observation of the antenatal encounters and discussions about transfer, none of the women intimated that transfer would be a site of contention in that there were no suggestions that they would dispute the decisions or the recommendations the SECM made. Some of the SECMs reinforced this opinion of their role in relation to the decision to transfer:

Enya (SECM):

I mean you don’t do it lightly, but you have to go with your professional opinion and the women respect that. So there can’t be any messing around ... if you have to transfer then you have to transfer.

Other midwives placed more emphasis on the women’s role in the decision:

Cora:

She [SECM] kept saying “look”, she said, “you’ll only go if you’re happy to go”. she was “if you’re going it’s because you’re going to want to go ... we’ll talk about it at the time”.

Armelle:

And we talked about transfer, and I said I'll leave it up to you [SECM], I told her I'd rather avoid it but that it would be her decision. And she said "Armelle, if you go into hospital, well first of all you'll need to go into hospital and you'll want to go."

These conversations were underpinned by the belief, on the part of both the SECMs and the women that they would be in agreement about transfer. The midwives made it clear that they would support the women to transfer (e.g. for pain relief) if they so wished. But the discussions demonstrated that transfer would be based on the midwives' professional opinion. ^{Fieldnote 18}

Ailis and Bridget (SECM), (observation):

They talked about labour and what it might be like for Ailis at home. Ailis asked what would happen if she decided she wanted to go into hospital – for an epidural for example. The SECM said – "I will support you to be at home until you say otherwise or until I am worried." They had a conversation of what might cause Bridget to "worry." Ailis appeared satisfied with all the explanations and the points the SECM raised.

The narratives shared by the study participants in relation to experiences of in-labour transfer show that the extent of negotiation and shared decision-making is greatly influenced by the reason for transfer and the urgency involved (Sections 8.3). Data that emerged from observations of labour at home and of transfer as well as from interviews show that, in some cases, discussions were held about the merit of transfer (in the 'non-urgent' situations). I have highlighted previously that there were no episodes of conflict between women and their SECMs about this (I am aware that this may be related to the specific participants of this study). However, in making sense of their experiences, women and SECMs did, at times, acknowledge having had 'I wonder what if' questions concerning their in-labour transfer. In these moments they did question and reflect on elements of the care (e.g. "*should we have transferred earlier?*" (Ailsa, Gilda, Clíodhna, [SECMs]), "*should I have stayed at home longer?*" (Cora, Clodagh), "*should we have called the 2nd midwife earlier?*" (Bríd). The influence that this has on in-labour transfer and the sense that participants make of their experiences therein will be explored in Chapter 8.

7.8 A Lasting Impression

The women's experiences of in-labour transfer occurred in the context of their readings of the maternity services and the interactions they had with healthcare professionals as they planned a home birth. These exchanges made a lasting impression and influenced women's perceptions and expectations of the interface of home and hospital birth.

7.8.1 'We're here if you need us'

Not all the interactions with hospital-based healthcare professionals were negative; for some of the women⁽ⁿ⁼¹⁶⁾ the experiences were encouraging. For example, Geraldine, Aoife, Ailsa, Alannah, Aideen and Cara spoke of the HMWs they met and their reactions to the plan of home birth.

Cara and Caoimhe (SECM), (observation):

Cara started talking about her booking visit at the hospital, she told the doctor that she was having a home birth. There was a midwife in the room at the time who asked her about her SECM. Cara told her and the midwife said "Caoimhe is really good and you'll have a great experience". Caoimhe chuckled about this, Cara pointed out that there wasn't really anything the doctor could say after that!

Ailsa:

I saw the consultant and she said "well you know where we are, and now we have a record of you" and "you know we are here if you need us" ... that was so positive, I didn't expect that.

Aoibh:

They had been grand with me and no one batted an eye when I said that I was going to have a home birth. Doctor [X] sort of looked over his glasses and said "well, you can come in to us if you need to." So I thanked him and said I hoped that I would not need to! But you know, it was nice of him to say that, he didn't need to say anything.

This was very different to the experiences highlighted in Section 7.5.2. With these interactions came an impression of support for these women: "I did not feel like I was doing something awful, like I had decided to do this bold

thing” (Rona). The idea of transfer to hospital did not appear to cause anxiety for women if they had a positive interaction with HMWs and doctors.

7.8.1.1 ‘They showed me around the labour ward’

Geraldine and Aideen gave a specific example of the support they received from HMWs and the impact that this had on their perceptions of hospital. The HMWs they met suggested that a tour of the labour ward would be useful.

Aideen:

They made an arrangement for me to see the labour ward. I hadn't even thought of that so it was really useful. And then if I had to come in I wasn't entering some place that was completely unfamiliar ...

These two women reacted positively to this experience. This positivity was not just in relation to the opportunity to view the labour ward environment, but also the opportunity to talk to a member of staff who was supportive of their decision and discussed transfer in a supportive way. They interpreted this as a really thoughtful, woman-centred practice for the midwives to suggest. Geraldine was “pleasantly surprised” by it all:

Geraldine:

They didn't have to do that. They weren't doing it for themselves; they were doing it for me, which was so thoughtful. The midwife was just so encouraging, at the end she just wished me luck with the home birth and said, you know, in the most encouraging way “I hope we don't see you in here.”

Participants of this study who had a professional knowledge of hospital or the maternity care system and the hospital-based midwives who participated in this study also proposed this as an exercise that can minimise the sense of unfamiliarity experienced by women during in-labour transfer. While it is not acceptable or necessary for all women, the midwives believe that it may go some way to alleviating “a fear of the unknown” (Clair, HMW).

7.8.2 ‘Why would I go back after that?’

Emerging from the negative interactions during their antenatal experiences, women expressed doubts about subsequent interactions with obstetricians and HMWs. They questioned the manner in which they felt they were treated. Those who had confrontations about the choices they made viewed all aspects of the maternity hospital in a negative light.

Iseabeal and Bridget (SECM), (observation):

Iseabeal, the previous week, had received a call from the hospital clinic to come for a blood test. She told them that she would sort it out with her own midwife ... she looked over to me and said “I’m sorry Linda, but why would anyone want to go in there again and be talked down to about having a home birth ... things they don’t know about?”.

Maura:

You know all they will do is make me sit for hours with hundreds of other women and then they will see me for 5 minutes. If they cop on that I am having a home birth it will turn into a lecture, why would I walk myself into that?

There was also a reluctance to have another encounter with the healthcare professional found to be unsupportive in the past and a fear that they could meet them again if they had to transfer to hospital.

Geraldine:

I know that I shouldn’t judge the organisation on that one doctor, but it was so difficult not to ... what if she was the one I met if I had to go in there again?

Cora:

I wasn’t going for another scan, what if it was that doctor I met ... what would I do then ... I knew that he did not agree with my decisions ...

This sense of dread and doubt in relation to the way they would be treated by hospital-based staff influenced their assumptions on how future encounters with hospital-based midwives and obstetricians would play out.

7.9 Summary

The themes introduced in this chapter illuminate the cultural context in which in-labour transfer occurs for the participants of this study. The findings explored highlight the interplay of social constructions of birth and the participants' experiences, illustrating how the cultural understandings of birth are exercised through everyday life.

The women who participated in this study planned a home birth. Their prior exposure to and knowledge of home birth varied, as did the factors that influenced their desire for this model of maternity care. The reasons for planning a home birth could be broadly classed as *what the women wanted* and / or *what the women wanted to avoid*. Regardless of the specific rationale underpinning their decision, the women were aware that their choice differed from, and even rejected, the dominant cultural understanding of birth in Ireland that is underpinned by obstetric discourses of safety and risk.

The experiences of the healthcare professionals were diverse, with variations in their perceptions of home birth and how valuable (and safe) an option of care they considered it to be. These perceptions, informed by social and cultural conditions and by historical events, were made known during their interactions with women. The manner in which women and healthcare practitioners negotiated⁵⁹ their understandings of birth influenced women's opinions of the maternity services, their regard for midwives and obstetricians, and their expectations about transfer to hospital. Some of the women⁽ⁿ⁼¹⁶⁾ spoke of positive and encouraging experiences in relation to the hospital practitioners reactions to their home birth plans. These women presumed a similar reaction if they needed to access hospital care. Others had different experiences and so assumed that the interactions at transfer would, at best, undermine their choices and, at worst, be confrontational and "*all that they did not want*" (Arlene) during childbirth.

The themes that emerged highlight the complex journey to home birth where constructions of safety and risk and perceptions of power play out

⁵⁹ During antenatal encounters.

during antenatal interactions between women and healthcare practitioners and influence the trust women place in the maternity services (and in specific professionals). Narratives of safety and risk, power and trust intertwine and underpin the experiences of in-labour transfer. These will be explored in Chapter 8.

The experiences of 42 women who planned a home birth and 39 healthcare professionals inform this study. Twenty-eight of these women did not birth at home. ⁶⁰The experiences of women ⁽ⁿ⁼²⁵⁾ and healthcare practitioners ⁽ⁿ⁼³⁹⁾ inform the next chapter.

(For Fieldnotes and Diary Entries please see Appendix 2, Pages 433 – 436)

⁶⁰ Appendix 5

Chapter Eight: Exploring In-Labour Transfer

8.1 Introduction

The previous chapter explored the discourses in relation to home birth and illustrated the complexities, contradictions and contestations that emerged from the data. This chapter will build on the themes raised and elucidate the experiences that participants of this study perceived as facilitating or constraining the interface of home and hospital birth. The chapter is divided into two parts:

Part I

This chapter opens by outlining the salient features that shaped the narratives that participants shared of their experiences of in-labour transfer. It also illustrates how women and SECMs negotiated care and the decision to transfer to hospital.

Part II

The data generated by my time spent in the field and by the interviews with the study participants are interwoven in an attempt to illuminate the experiences, and to provide both an emic and an etic perspective that raises understanding about the interface of home and hospital birth. In this I explore the sense participants of this study make of the interface of home and hospital birth and how their experiences (facilitating and constraining transfer) influence their perceptions of the future provision of maternity care in Ireland.

I outline fieldnotes and diary entries throughout this chapter and make reference to Appendix 2 when appropriate.

Part I

8.2 Great Expectations and Women's Spaces

Drawing on the large volume of data, this section provides a synopsis of women's⁶¹ stories that exemplify how their expectations of home birth played out and how these changed during the course of their experiences. In this retelling, the aim is not to explain in detail each woman's birth story, but to highlight the salient features that shaped the narratives they shared of their experiences of in-labour transfer. It also serves to illustrate how women and SECMs negotiated care and the decision to transfer to hospital.

I entered the research field without considering the excitement that I would feel at this stage of the study. The women I observed embraced the onset of labour. "*Labour started, yippee*" (Niamh). When I arrived at women's houses the excitement was palpable, and it was contagious.⁶² This was what they had been planning for; this is what they had been waiting for. Labour started at home and in those moments the women anticipated that this is where they would birth.

Ríona, (observation):

A call from Lana [SECM] ... Ríona said she was beginning to feel pains, but that she wasn't sure what was happening ... and was I ok, would I be around? Lana went to Ríona and then she went home, and then she went to Ríona again and she went home, and then in the afternoon when I felt that Ríona was getting a little embarrassed with all the coming and going Lana went to her again and then she phoned and asked me to come too!

The door was open and I let myself in. The lights were on in all the rooms and a hose was snaking from the bathroom up to the

⁶¹ I observed 10 women's labour at home; eight had home births, two experienced in-labour transfers and one woman transferred to hospital in the immediate postnatal period. The two women who experienced an in-labour transfer and the woman who transferred to hospital in the immediate postnatal period participated in interviews about their experiences. I had discussions with the other seven women about their experience of home birth and will draw on these observations and experiences when appropriate. I interviewed 22 other women about their experiences of in-labour transfer (Table 6).

⁶² Section 7.3.1 of the previous chapter highlighted the impression that these experiences had on me, a midwife, in that they reiterated my beliefs about birth, and the role of midwives supporting women during birth. They reflected my own expectations and plans for my first birth and some of my experiences. VCRM and the reflexive turn of this ethnographic research guided me in maintaining rigour in this study.

sitting room where the pool was set up in the centre of the room. There were Christmas bits around the place, toys and books that Riona's daughter (age 2) had scattered around the place before being whisked off by her grandmother and there was Riona in the pool, Kevin in front of her, Lana bending down beside her, fairy lights twinkling overhead! Riona waved and gave me thumbs up from the pool in between contractions. So there we were ... waiting for this Christmas baby to appear.

Leah, (observation):

The phone rang and it was Bridget [SECM] ... Leah was in labour and could I come when I was ready. My response was "yeah, excellent" ... because I had been waiting for Leah to labour, Bridget had been waiting for Leah to labour, Leah had been waiting for Leah to labour ... this was the longest pregnancy Leah had experienced and she was getting impatient for everything to start.

And there she was, in the sitting room ... Walking around with her hands on her hips, rolling on her ball ... breathing away during her contractions ... sort of in time to the music playing in the background on a laptop that was showing a slideshow of pictures of the other children. We all greeted each other ... this was it ... finally ... time for birth ...

Coupled with the excitement of four women ^(4 of the 10 labours I observed) was a sense of relief.⁶³ Their pregnancies had been approaching a gestational length no longer considered appropriate for home birth within the guidelines of the MOU; discussions of induction of labour were looming.

What struck me in those initial moments of shared anticipation was the sense of knowing and being known. I observed the impact that this had on the interactions between the women, birthing partners and midwives. The 'getting to know you' phase, which I had gone through so many times as a hospital midwife (HMW), was not required. Inconsequential conversation (unless desired) was not necessary; there was no pressure for making the kind of small talk I viewed as part of my midwifery toolkit, of trying to establish (in between contractions) who this woman was, what her expectations were about birth, what she needed and wanted. There was no

⁶³ The SECMs also expressed relief when spontaneous labour commenced for these women.

frantic asking of questions, flicking through hospital notes, looking at blood reports. This was a pre-discussed event. The required background information was known. The women and SECMs had established their relationships during the period of antenatal care. The focus was on the here and now and the needs of the woman, and on supporting her during her birthing experience.⁶⁴

Section 6.6 noted that the women's homes were diverse in location (urban or rural), infrastructure and content. Home birth in some areas in Ireland conjures up images of middle-class, well-educated women, with big, roomy houses full of the latest trends in baby care (physical and cognitive), all sourced from expensive brands that clearly advertise the 'research' underpinning the success of the product. In other areas of the country, home birth is associated with an 'alternative' lifestyle, chosen by women who make their own cheese, grow all their own fruit and vegetables and most likely have hens in their garden. These homes are shrines to the crafting skills of those who live in them. Many of the houses I visited fit these images, but not all the homes I saw slotted neatly into one or the other profile. What was apparent in all homes (observed by me and described by the women during their interviews) was the preparation of the environment, the preparation for 'this' particular labour and birth.⁶⁵

Eibhlin, (observation):

Her drawings and sculptures were all laid out on the mantelpiece in the room, all connected, all to do with birth ... what she envisaged it would be like ... what she hoped for her birth story, the pieces of flowers her friend had placed on her head during her special birth ceremony night, the new twigs of spring growth. We were inside this very ordinary house in an estate, like so many others in estates in Ireland. It was a rented house, the fixtures and fittings, the furniture etc were dowdy

⁶⁴ This contrasted with my observation of Ailis's transfer to hospital, when midwives spent a considerable length of time during the early stages of their interaction with Ailis searching for her hospital chart: "Where is her hospital chart? Why hasn't she a hospital number? ... What do you mean she didn't book with us, why wouldn't she book with us?" (Attracta, HMW), and when there was little regard for establishing Ailis's own views about her immediate needs.

⁶⁵ I viewed the hospital labour wards in stark contrast to this. They in no way concealed their underlying function to facilitate the medicalised model of birth. Drip stands, iv fluids, resuscitation equipment, beds with stirrups, silver trolleys with sterile 'delivery packs' all clearly visible.

and drab and not in keeping with Eibhlin's colourful garb. In this space she was creating a special birthing area, having their special "bits" around, making it like a nest, their birthing nest.

Iseabeal, (observation):

We were in the room that they had told me was without electricity. Candles and oil lanterns were placed all around, there was a turf stove in the corner – it was warm, it was so cosy – a cosy, very intimate birthing room. A pile of eiderdowns had made a bed in the middle of the floor and Iseabeal was kneeling on these and leaning forward onto Tadhg [husband] who sat with warm water in a basin beside him, every so often he soaked a cloth and placed it on Iseabeal's back ... Bridget in the background, watching and listening but not interrupting the natural rhythm of support that was unfolding.

The environment, the interactions, the care offered, all was highly personal. The women experienced labour (and some birth) in their own space where everything and everyone was focused completely on them⁶⁶ and on what they needed (see Section 7.2.1.1 and 8.10).

Norah:

I probably wasn't in full labour then but it really felt it and Caoimhe [SECM] had been there for a while because I needed her, I needed that support. And she was hungry and was gonna go off for breakfast and she said 'do you want to come to?' and I say ok, so we went up to the local coffee shop. So I was still having a few contractions and Cian [partner] was pressing the action points and in-between we ate breakfast. Then we came home and Julie [friend] came up to us. It was very sociable, it was a very sunny day so we all went for a swim in the sea, just across the road, it was so beautiful ... so there was my mum, Julie, Cian, Caoimhe and myself ... I think it was kind of a support, 'my team'. And afterwards I remember lying on a mattress in the sun as Caoimhe listened to the baby's heart ...

This was not just woman-centred care in the aspirations and rhetoric of health services' strategic documents and guiding policies; this was *woman-specific*. To borrow a word generally used in relation to commercial goods, what I observed and what the women recalled was *bespoke* midwifery care.

⁶⁶ The findings in Section 8.10 describes how experiences in hospital, at times, compare unfavourably and that women perceive the care they receive to be based on the needs of the hospital rather than on their personal needs.

Antenatally, women had emphasised their desire to be supported by a midwife who knew them and knew what they wanted and needed during labour and birth (Section 7.2.1.1). I observed and heard how this attentive, individual-specific care was given to the women at each stage of their labour and birth. For many of the women such care was missing from, and the need for it not acknowledged during, their experiences in hospital (Section 8.10.4).

I observed eight women birth at home. The emphasis on these experiences could be considered beyond the remit of this chapter; however, it is justified if only to distinguish them clearly from the ethnographic descriptions of hospital birth offered by participants of this study. I had considered myself 'home birth savvy' prior to my fieldwork; however, I reflected on and questioned the veracity of this belief at several stages of the study, when I found myself overwhelmed with amazement at the births I observed. ^{Diary}

^{Entry 1} In Section 7.3.2, I noted that hospital-based practitioners acknowledged that their lack of exposure to 'normal' home birth influenced their perceptions and that they, for the most part, associated home birth with poor outcomes. Such views come to mind as I seek to avoid overly nostalgic constructions of home birth while elucidating the contrasts to hospital birth as I observed them.

Niamh, (observation):

Bridget [SECM] whispering 'that's it Niamh, well done, that is so good' as Niamh cried out in pain ... and it just all happened so quickly ... and the 2 little boys at the door,⁶⁷ I remember turning to them and seeing if they were ok, and saying – 'the baby is coming' and they seemed a little curious but fine ... and then the bigger boy, the 5 year old – just as the baby's head crowned pulled the little one out of the doorway and they disappeared into the hall ... Niamh very quickly birthed her baby ... no one talked, no one told her what to do,⁶⁸ it all just happened and Bridget stood near and watched very closely.

⁶⁷ In their experiences of in-labour transfer, all the women spoke of the hospital policy on number of support people during labour. This was frequently used as a reason to ask an SECM to leave. When SECMs and husbands/partners were both 'allowed' to stay, this was viewed as the hospital being accommodating. The presence of older children during birth was not an option available to women who transferred to hospital.

⁶⁸ This differs from the 'directed pushing' experience women recalled during hospital birth (e.g. Aideen, Lana, Rona, Alannah, Carys).

Cáit, (observation):

... they had moved from the birthing pool, they just stopped in the doorway between the ensuite and the bedroom because Cáit said she could move no further.⁶⁹ Aoibh [SECM] encouraged her and held her and told her that it was nearly time, to lean into her if she needed to, the baby was nearly here ... and Jarlath [her husband] sat in front of her and said little. And then Cáit started bearing down, leaning back into Aoibh, holding Jarlath's hands ... bearing down and pushing her baby out into the world ... somewhere not quite in the bedroom not quite in the ensuite bathroom but certainly within the arms of her husband and her SECM.

Ríona, (observation):

... after Ava was born the 3 of them snuggled on the sofa, cushions and duvets everywhere and she breastfed. They ordered pizza and talked about the labour and birth over and over again ... Ríona kept marvelling at herself and her labour experience – ‘that was just amazing, I can't believe how amazing it was’. Carols in the background, lights on the tree flashing, smells of melted cheese and the slow gulp gulp sound of a baby feeding.⁷⁰ They didn't tell anyone, no phone calls were made, no texts sent, they wanted it to be just the 3 of them, in the morning they would tell of the Christmas present. We [the SECM and I] let ourselves out and just left them to it. We stood at our cars talking, giddy with excitement after such a birth.

Central to my observations was birth in women's spaces where the women were the focus and midwives made every effort to accommodate their needs. Antenatally I observed the preparation that went into making this possible and the time spent establishing relationships and negotiating women's expectations and experiences of care. Brigitte Jordan suggests that place of birth (birth territory) shapes the interactions between participants

⁶⁹ Very different to Cora's experience in hospital: "I wanted to squat on the floor and they wouldn't let me, 'oh no, you can't have the baby on the floor, you have to get up ... kneel on the bed if you want to do that sort of thing'. I was going 'no, I don't know if I can', and they were, like – 'no, you have to be on the bed, just turn around backward and get up'. So I had to ... and there I was, lying on the bed, in the one place I didn't want to be to give birth.

⁷⁰ 'Tea, toast and do your notes, get her into the shower and to the ward asap ... there's another woman waiting for that room' ... I have been that hospital-based midwife, practising in such an environment where women are moved to a postnatal ward as soon as is possible after they birth because there is a queue of women waiting to take their place. This could happen in the middle of the night and then partners are "sent home" (Ethna) 'so they don't disturb other women'.

therein “... birth, by the mere fact that it is located somewhere, inevitably takes place on somebody’s territory” (Jordan 1993: 67 [1987]). I observed birth in women’s territory; in this space, women plotted their journey, and SECMs their chosen map reader – “*watching over me, keeping it all safe*” (Rona). This is in contrast to some narratives of antenatal care (Section 7.8.2).

The women who birthed at home viewed this as an experience that had met their expectations of birth.

Caitlin, (observation):

Still in the birthing pool breastfeeding her newborn, Caitlin phoned her mother to tell of the birth, “amazing, all of it just amazing, even better than I thought it would be ... I’m so glad I did it.”

Eibhlin:

... it [the birth] was everything I dreamed of, that’s exactly what I wrote I wanted without realising that I could have that.

This positive attitude to home birth also emerged from the experiences of women who birthed in hospital. Only one⁷¹ of the women interviewed said that she would not choose home birth again.⁷² Some of the primiparous women^(n=12 / 17 interviewed) proposed that subsequent home births would be easier given that they now had experiences of labour to draw on.⁷³ Based on the perceptions of their experiences, 20 of the 25 women interviewed also

⁷¹ Ailsa birthed her first child at home – “*a fantastic experience*”; during her second home birth she transferred to hospital during the second stage of labour because of a retained placenta: “... *this one, it was a very painful, uncomfortable, unpleasant labour. Do you know there was nothing about it that felt like those things you would read in a book or that I felt the first time ... I could never do that again, never risk not having an epidural or something on hand*”.

⁷² Over the course of this research, four women who had experienced an in-labour transfer to hospital during their first labour birthed their second baby at home (Carys, Armelle, Cora and Sinéad). I spoke to them after their home birth. Cora and Sinéad spoke of the euphoria they associated with it: “... *actually staying at home, doing it this time, no drama, not going anywhere ... it was unbelievable*” (Cora). Armelle said she secretly thought it was an amazing experience but did not want it in any way to take from her feelings about her first birth. Carys referred to her second son as her “*healing baby*”, his birth the experience that “*took away the pain and awfulness*” of her in-labour transfer to hospital.

⁷³ The primiparous participants of this study made reference to characteristics of their labour they had not anticipated – eg, “*I didn’t think it would be so long*” (Alannah), “*I did not think it would be so painful*” (Maireád).^{Fieldnote 3}

suggested that, even if a home birth again ended with transfer to hospital, labouring at home for as long as possible would have a positive impact on their birth outcome. Home “*just gave me a chance for labour to happen*” (Blaithin).

Sineád:

... if I would have gone in [to hospital], if I'd never planned it [a home birth] and I'd have gone in, say the Saturday night, there's no way in hell they'd let me go as far as Sunday morning without drugs and stuff ... she [the baby] wouldn't have gotten a chance to turn herself naturally.

Gwen:

It was very long. I mean if I was in hospital I would have definitely got a c-section after a day or whatever, so I was lucky that I was at home for that time and I could give everything a chance.

Blaithin, Sineád, Gwen and Clodagh perceived that they would have had a caesarean birth had they not laboured initially at home. They assumed that hospital-based staff would have imposed a stricter time frame on the length of labour and as a result have initiated intervention (e.g. augmentation of labour) early. ^{Fieldnote 2}

Overall positive opinions of home birth were held by the women regardless of their actual place of birth; however, experiencing an in-labour transfer meant that certain elements of their expectations did not play out in their stories. I will address first the data concerning the negotiations of care and how birth moved to hospital.

8.3 Navigating Transfer in Women's Spaces

All the women were asked why they had transferred to hospital (Appendix 5). The most common reason offered by the women^(n=16, 14 in first stage, 2 in second stage of labour) was time, the length of labour.⁷⁴ Three women transferred because of meconium-stained liquor (these women also talked of ‘long,

⁷⁴ Discussions about maternal exhaustion and the baby in an occipito-posterior position were intertwined in some of these accounts; thus sometimes more than one reason was offered as a reason for transfer.

exhausting labours,' but suggested that it was the presence of meconium that made transfer inevitable). One woman requested to go to hospital for an epidural; one woman transferred because of fetal bradycardia in the first stage of labour, and two because of fetal malposition or malpresentation; one woman had a retained placenta and one woman transferred to hospital for perineal suturing immediately after the birth of her baby. Most of the women experienced a lead-in to transfer in that it was not a spur-of-the-moment decision.⁷⁵ Two of the women suggested that transfer came as "*a bit of a surprise when she said it*" (Sineád and Ethna). These women recalled strategies (suggested by the SECMs) they had employed to "*get the baby to turn*" (Sineád) and "*make the pains come closer*" (Ethna), yet in their understanding they did not assume that the next suggestion would be transfer to hospital.⁷⁶

The experiences of transfer to hospital were not viewed in isolation. In Chapter 6, I referred to the detail that women shared about the onset of labour⁷⁷ and the phases of labour they viewed as positive and in keeping with their expectations of birth. In these narratives the women identified when they felt that labour began to "*turn*" (Cara), the direction of their labour changed and the road to hospital began. Distinctions in their pre-transfer experiences and how these were negotiated and navigated also emerged from the data. How women interpreted these experiences was greatly influenced by their expectations of birth.

⁷⁵ Ailis transferred because of fetal bradycardia. This was the most 'urgent' of the stories, with no advance warning. There was a sense of urgency in the stories of transfer in the second stage of labour (Geraldine and Cara). The women with meconium-stained liquor (Blaithin, Armelle, Gilda), malpresentation (Arlene), retained placenta (Ailsa) and suturing needs (Eibhlin) did not consider their transfers as emergencies, but prompt action was taken to get to hospital. For women who labelled their first stage of labour 'long', the decision to transfer was not spontaneous; they spoke of time spent exploring all options and making plans prior to transfer.

⁷⁶ Sineád made sense of this afterwards by suggesting that she was so uncomfortable at this stage of her labour that her focus was on "*... getting through the next pain, I couldn't think of anything else*".

⁷⁷ Women recalled all aspects of their labour: when it commenced, who was present, when they decided to call the midwife, what care was offered, descriptions of pain and the techniques for relief, progress of labour (especially cervical dilation). The minute detail added to the ethnographic description of their experiences.

8.3.1 When Plans Change – ‘My labour went off track’

The majority of the women⁽ⁿ⁼¹⁶⁾ transferred to hospital because of labours they described as long and painful. Women spoke of their exhaustion (physically and psychologically), babies not rotating and contractions slowing down. Phrases such as “*it wasn’t working*” (Brid), “*I wasn’t dilating*” (Gwen) and “*there was nothing else I could do*” (Cora) emerged from the narratives. Some of the women⁽ⁿ⁼¹⁴⁾ (13 primiparous and 1 multiparous) suggested that the level of discomfort and lengthy time were not in keeping with their expectations.

Alannah:

I was really exhausted then and I decided to go and lie down and just give up with trying to get the contractions to be stronger and stuff. I hadn’t dilated in a good long time and I was just wanting to lie down for a while. So I went in to the bedroom and lay down but I couldn’t really lie down when I was contracting so I had to sit up every time so I wasn’t really getting any rest ... I was exhausted, I didn’t think it would be so hard.

Maireád:

The pain, it was awful ... it just kept getting worse and worse. I didn’t know how I was going to do it, the water wasn’t helping ... maybe if I knew it was going to be that sore it would have been better, but I just couldn’t believe pain would be like that

...

Coupled with these unanticipated happenings were misgivings about the route labour was taking. In describing these moments, women disclosed feelings of doubt. Many of the primiparous women⁽ⁿ⁼¹³⁾ suggested that labour was a “*lot harder*” (Jenniver) than they had expected, causing them to question the normality of what they were experiencing.

Aideen:

I was somehow feeling like ‘oh, things should be moving along a bit quicker’, it shouldn’t be taking this long and getting nowhere, there must be something wrong ... I asked and everyone was saying ‘oh, it’s your first baby, it takes a long time’ ... but it felt like this was too long, I just didn’t think it was normal.

Intertwined with the women's stories at this point of their labour were accounts of support they received from their SECM. The women⁷⁸ spoke of the manner in which SECMs sought to reassure them during episodes of uncertainty. Extracts from the women's interviews indicate that this reassurance related not only to physical support but also attempts to restore their faith in the process of labour.

Rona:

It was just strong, the pressure I felt to push but it was just too early. Bridget [SECM] was beside me the whole time and breathing with me [making breathing in and out noises], explaining what was going on. I don't think I could have done that on my own; I needed her beside me doing it ... because when she was there I felt what was going on was ok, that it wasn't all going totally off the track.

Clodagh:

[Clodagh was concerned that her labour was not progressing] ... they [SECMs] were saying "no, there's nothing wrong, the baby's fine where he is" and "we'll get you walking and we'll get that baby coming", and I was glad they did, it refocused me and we gave it a go for a while longer.

As noted at the beginning of Section 8.3, women in this situation had the opportunity to discuss options of care with the SECMs and together they devised a plan. Regardless of attempts to get labour "back on track" (Norah), this was often the time when SECMs also introduced the possibility of transfer. The women provided in-depth descriptions of "trying everything" (Rona) in an effort to relieve pain or to encourage the progress of labour. Several examples emerge from the data where midwives and women agreed to "give it x more hour(s) and we'll see what happens" (Armelle, Norah, Rona, Alannah), "try the pool again and see if that helps" (Gwen, Jenniver), "mobilise for a while longer" (Aoibh). However, all these experiences culminated in the decision to transfer to hospital.

⁷⁸ E.g. Ailis, Rona, Norah, Alannah, Blaithin, Armelle, Carys, Gilda, Aoibh, Clodagh. Two of the women (Bríd and Aoife) did not feel supported at this stage in their labour (see Section 8.3.4.1).

Armelle:

I could feel the child ... it felt like he was coming out of my bum with each pain, it wasn't nice. We tried all kinds of positions, so she [SECM] suggested listen we'll give it another hour. The baby might just click in and turn or else you'll be labouring for a long time. So she said "we'll give you an hour and we'll see then". I was like okay, that's grand, so another hour went and then she said "listen, I'm gonna check it" and she checked me and she goes "okay, he hasn't turned, I think it's time to go."

8.3.2 'I needed a little time to get my head around it'

In Section 7.7.3 I outlined the esteem in which the women held the SECM's knowledge and skills and their belief that she would know and say when transfer was necessary. The women who transferred to hospital because of concerns in the first stage of labour⁷⁹ recalled conversations initiated by their SECMs to discuss the reasons for and merits of transfer. Some of the women welcomed readily such discussion and the option of transfer (see Section 8.3.5), but three of the 14 spoke of needing time to come to terms with the "inevitable" (Carys), to accept the path of care suggested by the SECM.

Norah needed time to let go of her plans.⁸⁰

Norah:

I just so wanted to have the baby at home and I just cried and cried and cried. We were all crying, I needed the time to cry and get used to the idea ... it was letting go of my dream ... I was thirty-nine that day and was thinking 'well, I don't know whether I'm gonna get another opportunity for this [homebirth] ... I was very sad ... but I understood that I needed to transfer

Carys and Cora emphasised their need to be in control, suggesting they needed to take ownership of the final decision to transfer and how it was to play out.

Cora:

... she goes "I'll give you some time to think about it", and I lay down on the bed and she gave me an hour or so and then

⁷⁹ I am referring here to the experiences noted in the preceding section, where the first stage of labour was deemed to be long and painful, without the signs of imminent birth.

⁸⁰ Other women in the study – Aideen, Arlene, Jenniver – use similar language in terms of "letting go of all I dreamt for birth" (Arlene), but they suggested that this realisation came during their experiences in hospital, rather than pre-transfer.

she came back to me and she goes – “what are you thinking?”, and I had known from the minute she said “we’re going to have to think about transfer” that that’s the way it was going, and I just, I couldn’t speak, but yet I knew that I was going. When I was lying on the bed then I decided I was to go, I was happy to go. I changed my tack, because I couldn’t do it without being happy in myself. So I felt that I had to make it my own decision, making me feel like I was in control again, after that time on my bed I went “fine, I’m ready to go to hospital now.”

In their narratives, however, it is clear that they needed time to accept the suggestion made by the midwife (rather than to decide if they should transfer). They transferred when they “*were ready*” (Carys) and made sense of this afterwards as “*a transfer on my terms*” (Cora). The value these women placed on their perception of having the final decision is also evident in the women’s experiences in hospital after transfer (Section 8.10).

8.3.3 ‘She didn’t need to say anything, I knew that look’

Women who required a timely transfer did not have the luxury of prolonged discussions or considerations about their decision; a rapid response was required. Regardless of this, these women thought debates unwarranted; they stated that the move to hospital, suggested by their SECM, was necessary. Multiparous women⁸¹ said this knowledge came from the extensive discussions they had with their SECM during antenatal care when they had explored every eventuality.

Geraldine:

I don’t remember the difference or transition or anything, but I do remember the SECM saying “change positions” a couple of times and then she said “look, the baby is not coming, we’re going to have to transfer”, and we’d already had a plan, ... we had discussions about what could happen and I knew that if this happened I was transferring and what to expect.

Primiparous women, even those unsure about the normal course of labour (e.g. Maireád), proposed that the trust in their relationship with their

⁸¹ Geraldine, Alisa, Cara, Lana, Eibhlin, Blaitthin.

SECM⁸² guided their consent to follow whatever course suggested by the midwife (see Section 8.3.4). Examples drawn from my observations in the field of home birth demonstrate the interactions between the women and their SECMs and how the decision to transfer is quickly negotiated within their relationship of trust (See Appendix 2, Part II).

Lana and Bridget (SECM), (observation):

... “we may have to go in” Bridget said ... “let’s just see what happens with a few more contractions.” Lana assumed a position so the midwife could see her vagina during a contraction. Bridget asked if I could observe with her for 2 contractions and then some decisions would be made. I ok-ed my change in position with Lana and watched so intently. With the first contraction there was a trickle of blood ... and I remember looking at it and wondering – ‘oh, is there a tinge of meconium there?’ ... obviously Bridget was wondering the same thing as she picked up the pad and looked very closely at it, rubbed it, looked at me and shook her head. A 2nd contraction came, Lana pushed down and nothing happened ... Lana and Bridget looked at each other and at me ... nothing was said, everyone seemed to know ... Bridget reached for her phone, “I’ll phone them and let them know we are coming” ... Lana stood up, looked at her and said “I think so Bridget, don’t you, I need to go in”... and I started to look for Lana’s clothes and shoes.

Lana talked of this during her interview:

Lana:

... there probably wasn’t much to say, because I knew, I remember just looking at the two of you looking at my perineum and then ye looked at me, it was written all over your faces ... we were just all in agreement that it [labour] just was not working.

In my observation of Ailis’s labour, there was no preparatory discussion to the decision to transfer;⁸³ it was too urgent. Yet, in the moment, the relationship between Ailis and Bridget superseded any conversational requirement.

⁸² See Section 7.7. The women made reference to their trust in the midwife’s knowledge and skills and their expectations that during labour they would trust the decisions she made or pathway of care she suggested.

⁸³ See Section 7.7.2. Ailis and Bridget (SECM), (observation): Bridget said – “I will support you to be at home until you say otherwise or until I am worried”.

Ailis and Bridget (SECM), (observation):

Bridget listened to the baby's heart after a contraction with a handheld sonicaid, we could all hear – this time it sounded different ... I focused, it was slower, it took longer to get back to the racing dooo dooo dooo of earlier. I remember looking at them – I could see Ailis' face, she didn't register anything, she was getting her breath after the contraction, Bridget had her back to me, I couldn't see her expression at all. I heard her say – “oh, I am just going to listen in for longer and see what happens after the next one” ... her voice was different, it wasn't the soft, singing support of earlier – it was very focused, her words were very clearly enunciated – I think I would describe it as her 'posh phone voice'. I stood up and I remember turning my ear to the direction of Ailis' belly, waiting for the next contraction. I remember waiting to listen so very carefully.

We talked about this afterwards. Ailis said:

Ailis:

And Bridget [SECM], just said “we're going to stand up” and we stood up, and she just looked me straight in the eye and she just said “we have to go to the hospital now”, I said “ok”... now I could have said “will we wait for one more contraction” but in that moment, and in that time, and because it was Bridget, I was like “grand, that's what is going to happen”.

In these spaces women and midwives knew each other; both suggested that in-depth discussions were not necessary, and that agreement was negotiated through a well-established relationship.⁸⁴ Eibhlin's summarised this well: “*she [SECM] didn't need to say anything, I knew that look*” (Eibhlin).^{Diary}
Entry 5

8.3.4 Locating Trust in the Decision to Transfer

As the previous sections indicate, a common thread throughout the women's narratives and my observations in the field relates to the trust inherent in the relationship between the women and their SECM. Women referred to this during their experiences of antenatal care (see Section 7.7) and how it influenced their expectations of care during labour and birth. It emerged again in their stories and my observations of labour and the

⁸⁴ This contrasts with the experiences explored in section of 8.10, where women spoke of the challenges they associated with accepting care suggested by a healthcare practitioner that they did not know.

decision to move to hospital. Section 7.7.3 referred to the ‘*what ifs?*’ women expressed when reflecting on their transfer. However, these reflections took place ‘after the event’; none of these women suggested that they had any doubts about the care offered by the midwife or the decisions in the moment they occurred.

Women⁽ⁿ⁼²³⁾ made explicit reference to trust: “*I trusted my midwife implicitly*” (Geraldine), “*when the SECM was happy I was happy*” (Cara), “*the midwife didn’t flap, we took our lead from that. We knew that she knew exactly what she was doing*” (Gilda), “*we trusted in everything she said and did, so when she suggested transfer then we knew that transfer was the thing to do*” (Rona). Even where women expressed disillusionment with their labour, the trust remained (e.g. “*I lost faith [because of the intensity of pain felt], but not in her [SECM], I have complete faith in her, I want her to be my midwife for my next baby*” (Maireád). In Section 8.10.3, I will explore how these relationships of trust overshadow any interactions that women had with other healthcare professionals and influenced their experiences in hospital.

Section 7.7.3 referred to the theme ‘*I know my midwife will tell me if I need to transfer*’; women intimated that the decision to transfer would be guided by the recommendations of their midwife. This was reflected in their stories of labour. This ‘telling’ appears to differ from the negative ‘telling’ involved in ‘*they will just tell me what to do*’ (Section 7.2.1.2) that women offered as a reason to avoid birth in hospital and the routines of care offered therein. It was suggested by the women that any directions given by the midwife were acceptable because they occurred in the context of a previously formed relationship between people with a shared understanding of birth.

Eibhlin:

... because of this trust I let Bridget [SECM] guide my care. I knew her, I trusted her and I knew that her intentions are from a place of love for me and for my baby. She knew what I wanted and would protect that as best as she could.

I will return to this point in Part II of the chapter and illustrate how women in this study did not want this relationship and the guidance of the SECMs to end, even when they were no longer at home.

To provide an insight into diverse realities within participant groups it is important to draw attention to two of the women^(2/25) who did not hold similar experiences in that their narratives do not reflect confidence in their SECM.

8.3.4.1 'I had to initiate it myself'

Brid and Aoife said that they had found no comfort in the support offered by the midwife at this stage of their labour. They felt that the length of labour and the intensity of the contractions did not equate to the 'progress'⁸⁵ of their labour and were not convinced that home (or the SECM) held any other options. They stated that they had initiated and directed the transfer.

Brid:

And I figured I've done the birthing pool and I've done a shower, I've done the stairs, I've done the back of the chair, I've done the back rubs, I don't know what else I can do and so I kind of jumped up after that vaginal examination and said "right where are you bringing me because I'm not staying here any longer?" I was just three centimetres, nearly twenty-four hours, I'd used up everything. She [SECM] said "I was thinking we could do this, we could do that" ... but I said no, I'm not gonna go for a walk at two o'clock in the morning so that was that. So I said "I think I'm gonna go into hospital."

Aoife:

... she [SECM] says you have to stop pushing. And I said ok so I was trying all different positions, but nothing was helping, I just felt like pushing. So she examined me, she said "you're only 6cms, what do you want to do?" and I said I had enough,

⁸⁵ I use the word 'progress' with a heavy heart, but it reflects the way these women spoke of their experiences. In reflections during field work and data analysis I have several entries that question the perceptions of time and how the parameters of medicalised birth have crept into women's understanding of birth, even in those who favour normal birth. 'No progress', 'only x cms dilated', 'prolonged labour' were phrases that infused the narratives of all healthcare practitioners in this study. As I write the final version of this thesis, I have read again my own personal story of home birth – I too requested VEs as a means of assessment. I had forgotten this and find it interesting that I too allowed elements of medically managed birth to stay in my understanding of normal labour.

now I am going in ... she wasn't doing anything anyway that helped me so there was no point being there anymore.

Both these women revealed the breakdown of their relationship with their SECM at this stage. This was not in keeping with their expectations of home birth and the connection that they anticipated they would have with their midwife at this stage. When remembering the period prior to transfer, both women questioned the support they had received from the SECM, saying it did not meet their needs at that time.

Brid:

I needed more verbal support, I needed to be told 'you are strong, you can do this', I don't remember hearing anything like that, I needed her to reassure me that it was ok and not be so distant ... I needed to hear that.

Aoife's experience is the most negative, and she is the only woman who transferred⁸⁶ her trust completely from an SECM to hospital-based staff in the middle of labour.

Aoife:

... we were getting ready to transfer and that was it, I'd had enough and didn't want her there anymore. I was just doing my own little thing at this stage. I wish someone had guided me but anyway it didn't happen ... I just wanted her to go, I wanted to go into hospital and hopefully someone would sort me out.

Aoife stated that she had felt “*relieved*” once the decision was made and the journey to hospital began.

8.3.5 Making Sense of the Decision – ‘I was getting ready to go and I felt...’

During interviews, women talked about their reactions to the decision to transfer and the realisation that they were not going to experience home birth in this case.⁸⁷ Responses ranged from ‘disappointed’ (gutted, upset,

⁸⁶ Some women extended their trust to include hospital-based practitioners, but Aoife was the only participant to state that she had developed an irrevocable distrust of her SECM and no longer wanted her care.

⁸⁷ Some reference to the initial reactions of women in a *non-urgent* transfer experience can be read in Section 8.3.2.

sad and lost) to 'relieved'. Eleven of the women said that they had felt scared. Women's feelings varied depending on the reason for transfer and the reception they anticipated they would receive from hospital staff. ^{Fieldnote 6}

Relief about the decision to transfer was expressed not only by Aoife but also by other women⁽ⁿ⁼⁹⁾ in the study. However, the reasons offered by these women differed from Aoife's explanation.

Gilda:

I was just tired ... I was really, really tired, because I hadn't slept for two nights ... you convince yourself that you can't cope and I was so glad that we made the decision to transfer.

Maireád, Sineád, Alannah, Caitlin and Ethna thought that transfer to hospital would mean an end to pain and exhaustion. Maireád wanted an epidural; Sineád and Caitlin said they needed "*something to make the baby come and be done with labour*"; Alannah "*just wanted it to end*" and said: "*In hindsight I'm not sure what I thought they would do for me in hospital but I just wanted the labour over.*" Aideen, Lana and Ailsa expressed relief also. Their relief was coupled with their understanding that they required support in labour that was specific to the hospital (e.g. "*I was just relieved actually, I was really glad we were going because I just really felt I needed help*", Lana). These women viewed their transfer as unavoidable (a sentiment also articulated by the women who had meconium-stained liquor), as remarked by Blaithin: "*Sure what else could I do?*" An my diary ^{Diary Entry 7} demonstrates my surprise that the women in non-urgent transfer cases did not call into question some of the criteria for transfer stipulated by the MOU (e.g. transfer solely on the basis of 'light' meconium-stained liquor was critiqued by the SECMs: see Section 8.4.3). However, on further reflection it must be noted that this may be particular to this cohort of women and the reasons for their transfers.⁸⁸

⁸⁸ As noted in Section 8.3, women who transferred because of meconium also referred to the challenges they faced because of '*long, exhausting labours*'. The women believed that meconium was, in a sense, the final signpost in a journey already heading toward hospital birth.

Section 7.6.1 referred to the perception that an obstetrician could ‘*take away my home birth*’ based solely on their personal interpretations. The women paid little attention to the criteria of the MOU that stipulated “planned birth at an obstetric unit”; personal opinions were thought to be the deciding factor. Similarly, the decision to transfer was viewed in the context of the SECM’s knowledge rather than the socially constructed framework of the MOU.⁸⁹

Regardless of how appropriate the women considered the decision to transfer or how necessary they deemed it to be, this experience was not without disappointment. All the women stated that they were disappointed that their plan to birth at home did not come to fruition. Some felt that their bodies had let them down (e.g. Carys, Cora, Aideen, Lana, Maireád, Arlene); others that their belief in their ability to labour and birth wavered (e.g. Gilda, Alannah, Clodagh, Jenniver, Bríd). Even the women who suggested that birth at home was ‘*just not meant to be this time*’ (Aoibh, Rona, Gwen, Armelle) expressed disappointment that they had not lived out their expectations.

The other dominant emotion to emerge from the data was fear.⁹⁰ This was expressed by 11 women, who identified clearly the source of their fear. They did not feel that transfer was the incorrect decision but they felt scared of what would befall them in hospital. Jenniver, Lana, Aoibh, Ailis, Cora and Gilda were concerned about the hospital-based practitioners, because they could not choose who would care for them. Some of these fears derived from antenatal experiences: ‘*What if I meet that doctor who was so awful to me in the clinic?*’ (Cora, Ailis).⁹¹ Others (Gilda, Jenniver, Lana, Aoibh) were worried about interactions with someone who did not support home birth and the potential impact of this on their care. Carys, Arlene, Bríd, Sineád and Cara advanced the previous point by stating that they were

⁸⁹ I will return, in Section 8.9.1, to this perception that personal interpretation influences the care women receive and in turn how the obstetricians feel that this view leaves them open to ‘blame’ when women do not ‘get’ the home birth they expected.

⁹⁰ Other women talked of feeling worried but suggested that this was just a general feeling arising from exhaustion, pain and the trepidation associated with plans changing. It was not identified as their central reaction to transfer.

⁹¹ See Section 7.5.2.

scared “*of what they will do to me*” (Carys). This is reflective of the issues raised in Section 7.2.1.2 (*‘I’m afraid of what will happen in hospital’*), when women voiced concerns that care in hospital was based on routine intervention over which they would have little control. Women feared that they would have “*a fight on my hands*” (Geraldine) in order to retain any voice in the pathway of care in hospital.⁹²

In Section 8.3 (and Appendix 2, Part II), I present extracts from my fieldnotes focusing on my observations of in-labour transfer. These passages, in combination with women’s narratives, serve to provide an insight into the negotiations and navigations that occur prior to transfer to hospital. I have referred explicitly to experiences that women identified as influential on their interactions with hospital-based practitioners at the time of transfer and their perceptions of the care offered in that environment. It is important also to discuss the data that emerged in relation to the SECMs’ perceptions of transfer, specifically issues that influenced their reading of their interactions with HMWs and obstetricians.

8.4 ‘Calling time on home birth is disappointing but there is always a good reason’

Women referred to transfer as ‘disappointing’. This was also a view expressed by all the SECMs.

Caitriona (SECM):

Often when you think back you feel disappointed. These women plan a home birth, that’s what they’ve set their sights on and you are there to support them during that. So of course, it is terribly disappointing for everyone when that doesn’t happen.

Siofra (SECM):

It is unfortunate, completely disappointing. But it is what it is ... sometimes that’s just the way it is and we all have to just accept that and make a new plan.

SECMs were pragmatic in their responses; they acknowledged that transfer altered women’s plans and that this was not without consequences for their

⁹² Section 7.5.1

experiences. However, all the SECMs held it as important that they were honest with women and offered their unreserved “*professional opinion*” (Isla, SECM) when they deemed transfer appropriate.

Eimear (SECM):

Women plan to labour in a certain way, in a specific place with a particular type of care, a specific midwife ... so yes I know that seeing that disappear is hard, but sometimes, for whatever reason, you have to call time on it and say home is no longer the place to be, say to the woman ‘I think you need something different now’.

As noted in the women’s narratives, some transfers were more acute than others. The SECMs provided numerous examples, in keeping with the women’s accounts (see Section 8.3.1), describing the care and revised care they offered in an attempt to support women in “*whatever labour brings, be that pain, long hours, tiredness*” (Bridget, SECM). Consistent with the women’s experiences, midwives recalled scenarios where women’s needs could no longer be met at home by the SECM (e.g. pain relief, augmentation of labour, instrumental births). They also identified (and I observed) situations where rapid transfer was required, with no room for hesitation. Regardless of the scenario that initiated transfer, the midwives agreed that “*it’s not done lightly; there is always a good reason*” (Enya, SECM).

8.4.1 ‘The women know me and I know them’

All the SECMs suggested that the relationship they established with women during the course of pregnancy was crucial during experiences of transfer. It was considered crucial to negotiating transfer (both acute and less urgent) because any suggestion or recommendation was made in the context of a shared understanding of birth.

Maeve (SECM):

Sometimes it is really difficult when you have to start talking about transfer, because you know home birth is what they wanted, it’s hard. But you know them so well and they know you ... so they know that you are only suggesting what you think is the right thing for them ... it’s not like you are

purposively doing something that was not part of their birth plan.

The SECMs were aware that the women trusted them, and trusted their midwifery knowledge, skills and ability to “*look out for them during labour and make sure everything is going the way it should be*” (Enora, SECM). This is borne out in the women’s narratives (explored in Section 8.3.4) and in the value women placed on the opinions offered by a midwife they knew. It is also in keeping with my observations of labour at home (see Section 8.3.3). I saw women and SECMs negotiate labour and transfer within a mutual understanding of birth, with little verbal communication; both participant groups suggested that dialogue was often unnecessary in a well-established relationship that had explored everything during the antenatal period (Appendix 2 Part II).

The obstetricians held a different opinion in relation to the close relationship constructed by SECMs and women. Eileen, Brenda and Sheena (obstetricians) viewed this relationship as a potentially negative influence on the decision to transfer. They suggested that knowing a woman and her wishes to this extent ran the danger of influencing the SECM’s judgement, causing her to “*move her goalposts*” in relation to care because “*they want to do all they can for her to have her home birth*” (Eileen, Obs). Sheena and Triona (Obs) proposed that this placed midwives in danger of assuming the role of a friend rather than a ‘professional’. After this had emerged from the interviews with obstetricians, I returned to five of the SECMs to ask them if they too held it as a concern. The SECMs intimated that this opinion might be informed by anecdotal, historical events. However, in the current culture of the maternity services in Ireland, they suggested that, in their experiences, ‘the friend versus professional’ scenario was not the case. The midwives referred to the terms of the MOU, suggesting that its criteria do not facilitate such latitude in care. The SECMs proposed also that this opinion does not take into account their “*professional accountability and the evidence-based practice*” (Caitriona SECM) they ascribe to.

Enya (SECM):

Why would we stay at home if it was going to make a situation worse, it's not home birth at all costs, it's a safe woman and a safe baby, that's the priority.

The diverse positions held by the SECMs and obstetricians do not go unnoticed during the interface of home and hospital birth. SECMs spoke of “*feeling judged by [hospital-based] staff*” (Cliodhna, SECM) in relation to the decisions they make during home birth. HMWs and obstetricians suggest that SECMs have promised women “*things that are no longer attainable*” (Fiona, HMW). The influence that these perceptions have on the experiences of transfer will be addressed in Section 8.7.

8.4.2 ‘You hope you called it right’

The SECMs’ experiences did not feature incidents of conflict in about the decision to transfer.⁹³ SECMs talked of the discussions they had and revised plans of care that were made,⁹⁴ but did not refer to any cases of women choosing to remain at home even when transfer had been recommended. Nonetheless, and in spite of the value they place on their relationships with the women, this was a concern voiced by some⁽ⁿ⁼⁶⁾ of the SECMs.

Naoise (SECM):

It has never happened to me, it would be a dreadful situation, for everyone. You hope it wouldn't happen, that you would always be in agreement ... but life doesn't always work that way and there is always the chance that it could happen at some stage in the future and where would that leave us?

The SECMs suggested that the Nurses & Midwives Act (Government of Ireland 2011) places them in a vulnerable position, giving little guidance should such a scenario arise. In light of the MOU (Chapter 4) it has been argued that, if circumstances change in labour that require transfer and where the woman chooses to stay, the midwife is caught between abandoning the woman or operating outside the MOU, without insurance,

⁹³ I am aware that this may be specific to the participants of this study.

⁹⁴ E.g. revised care may have included “*We'll reassess progress of labour in x [time] or let's try a different position and we'll see if that is of any comfort*” (Rosa, SECM).

and thus acting illegally. The midwives labelled this concern as “*hypothetical, might never happen*” (Bridget, SECM), yet in the current culture of maternity care in Ireland they indicated that it was “*another thing to add to the list to worry about*” (Caoimhe, SECM).

In the previous section I documented that all the SECMs in this study were pragmatic in their explanation that transfer happens for a reason; this does not mean that the midwives did not reflect on, question and worry about some of their experiences. SECMs’ anxieties around transfer related to their decision-making: “*Did we transfer too early?*” (Siofra, SECM); “*Was there anything else we could have tried?*” (Janet, SECM); “*Should we have gone for pain relief earlier?*” (Caoimhe, SECM).

Ciara (SECM):

You worry ... ‘Did I call it right? Did I do this right, should I have done that?’ And you know everything may be fine and the woman may go on and have a grand experience but in the moment and still afterwards you still thrash it out and wonder ... you have to, otherwise you’d just become complacent in your practice.

The SECMs in this study talked of reflecting on their practice; this included reviewing the experiences with women, and informal and formal reflection with peers.⁹⁵ Debriefing with women was held as necessary and unavoidable, given that (as pointed out by the SECMs) the midwives continue to support these women during the postnatal period. I observed some of the informal reflection sessions among the SECMs. These I perceived to be a mixture of a support group, teaching sessions, research cluster and critique club, depending on the needs of the SECMs in the specific moment. Session title and specific remit aside, this mechanism of peer review and support was not viewed as a weakness in their practice, but rather as an essential element.

⁹⁵ Peer review is a requirement of members of the Community Midwives Association (CMA).

Eimear (SECM):

Oh you have to talk to the others [SECMs] about things. Even when you are at home, and there is a second midwife there and ye are making sense of things together, you still have to talk about it afterwards ... I mean, no disrespect, it's not like you are in hospital and you can just press a bell for someone else to come and make a decision, you are 'the one' there and you have to make sure that what you are doing is ok and that you learn from everything that happens be it good or bad.

Peer review and the support therein was offered after the event; in the moments of transfer midwives⁽ⁿ⁼¹⁰⁾ spoke of other concerns they held. In addition to the anxiety caused by the need to transfer to hospital, midwives also noted that they dreaded the judgmental attitude they associated with hospital-based healthcare practitioners.

Leah (SECM):

One experience was particularly awful, everything happened ... in the ambulance, I saw meconium and I was like, oh no, and the fetal heart had been fine but now it was dipping and so I remember being really anxious bringing her in thinking 'oh my God I hope we haven't left this too late' because everything had been fine, we were transferring because I was worried about time frames and then so I was thinking – 'oh no this is bad' ... and I just knew the reaction I would get and questions implying that I had done something wrong. So I was dreading that on top of everything that was going on with the woman ...

These SECMs perceived that, during their interactions with the hospital, the midwives and obstetricians would call into question all the care and decisions made during labour. This holds true for some of the experiences and will be explored in Sections of 8.7.2. ^{Fieldnote 8}

8.4.3 'The MOU, it's never far from your mind'

The SECMs in this study had diverse opinions about the MOU, the evidence underpinning some of its criteria and the impact⁹⁶ that it has on their autonomous midwifery practice. Three of the SECMs had confidence in the agreement and perceived it as offering support to their midwifery practice. These midwives suggested that because of the MOU there is no

⁹⁶ Twelve of the SECMs suggested that elements of the MOU do not take into account the autonomous nature of midwifery practice and the "skilled decision-making that is integral to the profession" (Caoimhe, SECM).

ambiguity in relation to, for example, transfer and when hospital-based care needs to be instigated.

Enya (SECM):

I think the MOU is good, it has good guidelines, and sets things out the way it has to be. And as long as you keep within the MOU and local guidelines, then you are fine, no one can touch you and say that you did something wrong.

Their comments on the positive features of the MOU all centred around the same point, namely that their practice and their decision-making would not be open to “*criticism and blame*” (Eimear, SECM) once they kept within the explicit parameters of the MOU. The other 12 SECMs were not convinced about the appropriateness of all aspects of the MOU and the impact it had on their practice. They critiqued several of the directives that they did not believe were based on evidence.⁹⁷ Nevertheless, they stated that they were bound by the agreement and had to work within the guidelines.

Regardless of their personal opinions about the MOU, 12 of the SECMs participating in this study stated that “*it’s never far from my mind*” (Isla, SECM) during episodes of care. Some of the midwives, who have supported home birth in both pre- and post-MOU periods, articulated the positives and negatives associated with each period. While evidence-based guidelines in a supportive structure for home birth were held as preferable to having no framework, these midwives questioned the impact of some of the stipulations on midwifery practice and suggested that midwives who have entered the field of home birth more recently practise in a culture influenced by the obstetric discourse of risk.

General discussions about the HSE guidelines were initiated by the SECMs, as well as (of particular interest to this study) critiques of the indications for intrapartum transfer as cited in the MOU. The midwives drew specific attention to two of the directives: intrapartum transfer for “delay in the first

⁹⁷ At several points of this study, members of the CMA were involved in a process of critiquing and offering the HSE feedback about the MOU and a revised edition of the MOU. Several of the SECMs believed that their points had not been taken on board.

or second stage of labour” and “meconium-stained liquor”.⁹⁸ Distinct interpretations of the recommendations, informed by understandings of birth, were held responsible for confrontational interactions between SECMs and hospital-based staff.

Naoise (SECM):

... sometimes it is not that 'black and white' and that is the problem when you are trying to justify what you did, and sometimes what you didn't do, to people who view it to the letter of the MOU. Delay in the first stage of labour, I mean what obstetrician is ever going to agree with me in relation to this, in Ireland, the home of active management ...?

The SECMs felt that their care and decision-making skills were questioned within a framework of medically managed birth. Six of the SECMs said that such experiences influenced their practice and suggested that at times it felt like the care they offered was “*not just woman-centred but also MOU-focused*” (Caitriona, SECM). These midwives proposed that this was a strategy they adopted in an effort to avoid “*leaving myself open to criticism that I was working outside the MOU*” (Cliodhna, SECM). ^{Diary Entry 9}

Caitlin and Ciara (SECM), (observation):

A funny 'pop', Caitlin's waters had gone and Ciara, standing at the edge of the pool said “meconinum, I think I see meconium” ... she was looking at the pool and looking to me and she was frowning. She asked Caitlin to get out of the pool because she would have to check and see ... so we helped Caitlin out and she slowly, awkwardly walked over to the couch with Ciara saying to her “if there is meconium we will just have to go to the hospital”, talking of hospital before an assessment was even made ...

Ciara and I talked about this afterwards:

I probably seemed obsessed, with the meconium ... I just know what they [hospital-based staff] are like and the reaction you get. And it's all your fault, 'you saw meconium and you didn't transfer in, what were you thinking?' I am obsessed with it, you get no support if something happens then and you've

⁹⁸ I made a brief reference to the midwives' concerns in relation to this in Section 8.3.5. SECMs suggested that this does not take into account, for example, the grade of meconium, other assessments of fetal wellbeing, stage of labour, the woman's parity, and the gestation of the pregnancy. The midwives suggested that this isolates one aspect of a bigger picture of assessment.

stayed at home, even though it could have been the right decision at that time and then before you know it people are complaining to the HSE about your practice.

Section 8.3.5 noted women's fears about transfer. The SECMs did not say they were fearful but some⁽ⁿ⁼⁷⁾ disclosed moments of unease prior to engagement with the hospital – unease caused, in their view, by their expectation that the interactions with hospital staff would leave them in a position where they would have to defend their practice, defend home birth and justify the appropriateness of supporting home birth, when in this scenario transfer was required.

Siofra (SECM):

You know they [obstetricians] are looking at you as if to say 'told you so' ... actually that is not fair 'cause they are not all like that, but some, the ones that don't support home birth, you just know that a transfer in some way affirms their opinion.

Enora (SECM):

I used to dread it [transfer]. Dread the comments, dread the way they look at you, dread what they say to you, dread what they say behind your back. But I've had to get past that and know that transfer is not a sign that women should not have home birth, transfer is a sign that I did what I was there to do.

8.5 Summary Part I

This section has presented women's and SECMs' experiences of negotiating the decision to transfer to hospital. The themes explored relate to the experiences they deem influential on their expectations of interactions with hospital-based practitioners at the time of transfer and their perceptions of the care offered in that environment. The next section explores how these constructions contribute to the interactions at the interface of home and hospital birth in Ireland.

PART II

Chapter 7 explored the complex journey to home birth; constructions of safety and risk as well as perceptions of power were noted during interactions between women and healthcare practitioners. These themes extend and influence the interface of home and hospital birth and the establishment of trust therein.

Ailis and Bridget, (observation of in-labour transfer):

Bridget asked me to phone the hospital and let them know we were coming in as she continued to support Ailis during her contractions and at the same time manoeuvre her toward the front door ... so I did, I asked to speak to the midwife in charge of the labour ward, to which I received a clipped YES, I gave her a brief outline of the scenario ... then the midwife on the phone started asking me questions – what was her hospital number, would she need an instrumental, what station was the baby's head at, if we had phoned an ambulance, all in the one breath ... Throwing questions at me as I was trying to get off the phone and help Bridget. I asked Bridget about the ambulance – “no we'll bring her in, it will be quicker than waiting”, to which I received a snort from the midwife on the phone, “no ambulance, it isn't that big a deal then is it” and so ended our conversation, she hung up ...

8.6 'It's all who you know'

Part I described the value that women and SECMs placed on knowing each other prior to their experiences of labour and transfer. The benefits of their acquaintance were contrasted with the limitations they associated with the “*unknown person*” (Gwen) they expected to encounter in hospital. Their stories included accounts of SECMs trying to circumvent elements of the unknown by transferring to hospitals where they were familiar with some of the staff, or hospitals considered more home birth-friendly than others.

Eibhlin and Bridget (SECM) (observation of transfer):

Bridget assessed Eibhlin's wellbeing after the birth and after discussion between them it was decided that it would be better for Eibhlin to transfer to hospital. Bridget made the phone call to liaise with the midwives, afterwards she said to Eibhlin “it's great, I phoned [hospital x] instead of [hospital y] and [name] is in the labour ward today and she said we should go straight in and look for her and she'll sort us, that's great, there'll be no fuss or drama with her there.

Janet (SECM):

If at all possible I transfer to [hospital x], because this is the one I know best. They know me, they know how I work, they've experience of me over the years. Of course you meet some midwives who are more open to home birth than others but I always hope that there will be someone there I know when we go in, that makes it all so much easier.

This tactic was mooted because the SECMs thought “at least if they know you, they are open to listening to you, working with you even and don't just write you off the second you come through the door” (Leah, SECM). Twelve of the women noticed that the midwives knew each other and some⁽ⁿ⁼⁷⁾ interpreted this as beneficial to aspects of their experiences in hospital. Diary Entry 10

Cara:

So the midwife knew Caoimhe [SECM] and immediately there was a warm atmosphere there. She was saying some really warm things to us ... taking me in as an individual and she was being quite supportive. And I do think that made all the difference that she knew Caoimhe and that they were able to chat away to each other and she listened to Caoimhe, telling her all about me and what I had planned.

Aoibh:

... we went in and met this midwife that Caitriona [SECM] had worked with at some stage. And Caitriona said – “listen we've tried a, b and c, and now I think Aoibh needs x and y” and so they went with that and did everything that she asked.

Five of the women intimated that it was not always advantageous that the midwives had knowledge of each other.

Carys:

They weren't happy to see Peig [SECM], I could tell. We arrived in and ...we told the staff that she would be staying with me and that my husband was choosing not to stay. And then the problems started. I was told “no, your husband should be with you, we can't have Peig here”. Obviously Peig was known to the staff, 'cause I don't remember anyone introducing themselves but they all knew her name ... the charge midwife took my SECM outside and spoke to her and I'm not entirely sure what she said to her but they got her to

stay outside and got me on my own and came into me and I can remember her saying “look at me Carys, look in my eyes, pay attention”. Of course I was labouring, I was like, ‘WHAT’? She said to me “Carys, you're putting the independent midwife in a very difficult position, it's not fair that you would do this to her and ask her to stay”. And of course my thought was that the SECM had said that ... I found out afterwards that someone was outside the door saying to the midwife – “are you sure Carys wants you to stay, you are putting her in a very difficult position assuming that ...”?

Carys interpreted this as a very definite plot to “get rid” of her SECM. In these experiences the women spoke of curt interactions between the SECMs and HMWs, with no question of the SECM remaining in the hospital for any length of time:⁹⁹ *“they couldn’t get her out of the room quick enough, they weren’t too interested in what she had to say and there was no way they were allowing her to stay”* (Brid).

HMWs also commented on their experiences when they were familiar with the SECM. Section 7.3.2 outlined the negative perceptions some of the hospital-based practitioners associated with transfer from home. However, in the circumstances where the SECM was known to midwives, this sometimes did not hold.

Ava (HMW), (observation of in-labour transfer):

One of the midwives came up to me in the labour ward, asked me how my study was going and said - “I heard Bridget [SECM] was coming in with a woman, I must pop down and say hello.”

Mary (HMW):

Look we know [SECM] for so long. We’ve worked with her, she’s helped us out, we help her out. We are all in awe of her around here to be honest, so if she is transferring a woman in, well firstly it is warranted and secondly the care beforehand will be spot on and we all know that.

The HMWs⁽ⁿ⁼¹⁶⁾ suggested that any concerns they had in relation to SECMs were informed by stories they had heard in the hospital. While positive

⁹⁹ The significance of this in women’s experiences will be explored in Section 8.9.2.

cases and interactions affected the standing of the SECM within the hospital, so also did negative experiences.

Mona, (HMW):

A few independent midwives have a bad reputation as far as [hospital name] are concerned. There's been a few bad outcomes, it's like word of mouth – mec babies coming in, with women that haven't been transferred early enough in labour. So when that SECM phoned me I was thinking 'oh God, the bad outcomes I've heard about in her cases'...

The HMWs admitted that their expectations about the “*way the labour was managed*” (Clair, HMW) and the decisions SECMs made were influenced by what they had heard about the SECM. For these midwives, their interactions with SECMs played out against a background of suspicion where the worst was assumed in relation to the “*condition the woman and baby will be in*” (Myrna, HMW).

The obstetricians acknowledged that they had some insight into the “*reputation*” (Eileen, Obs) of the different SECMs working in the vicinity of the maternity hospital. However, they did not focus on positive attributes, but instead expressed a negative impression of some of these midwives.

Sheena (Obs):

I'm not sure that I like to see any of the home birth midwives coming into the hospital, to be honest, because it means something has happened, but there are definitely some that I would rather see than others. There are some and you know 'this is just going to be hard going' and no matter what you do it'll be wrong.

Brenda stated that she had “*no positive experience*” of transfer to draw from. As an obstetrician, she proposed that she only became involved in care when “*an incident escalates up, when the management at home is seen as being inappropriate or the patient does not want to take the hospital's advice*”.¹⁰⁰ It was this obstetrician's belief that all transfers from home birth brought cases and interactions that were difficult and challenging.

¹⁰⁰ The other three obstetricians also made this point.

8.6.1 Historical Hurt

HMWs and the SECMs were aware of poor interactions and past cases that gained notoriety among healthcare professionals in the maternity services in Ireland. While none of the SECMs allowed that their personal reputation might account in part for fraught interactions during transfer to hospital, some ⁽ⁿ⁼⁵⁾ made generic references to SECMs whose relationships with the hospitals they considered strained. These midwives suggested that this was not good for home birth, and that all SECMs needed to be aware of the impact of confrontational relationships.

Maeve (SECM):

You can't have a few, always fighting and arguing while the rest of us are just getting on with it, everyone just needs to work together, no one is above this. We all need each other and no one should think otherwise.

One HMW referred to the “*historical hurt*” (Alva, HMW) associated with transfer from home birth, causing a long-standing reproachful attitude towards SECMs.

Alva (HMW):

Some women came in and really they were in a mess by the time they got to us, prolonged labours, babies in poor condition ... it wasn't good ... home birth really got a bad name and that has lasted. Now some of the midwives today are showing us that this doesn't have to be the way and we can all work safely together, but I don't know if everyone has caught up that these kinda midwives are there too.

The doubts these scenarios instilled continue to inform the current obstetric discourse in relation to home birth, transfer to hospital and SECMs. The HMWs appeared to have an opinion about individual SECMs as opposed to an all-inclusive judgement of the current cohort of midwives. In contrast, the obstetrician's ⁽ⁿ⁼³⁾ criticisms of past actions of some SECMs informed their current opinions of all of them.

Brenda, (Obs):

I think it's almost indescribably bad ... that you have a group of people operating independently outside the healthcare

system with very little regulation and very little links in to the, the hospital system.

Well, independent in this context means very independent. If you look at An Bord Altranais's attempts to regulate, An Bord Altranais has found it very difficult, so their own professional body has found it difficult in the extreme to regulate this and if you're independent from your own professional body you are truly independent.

I think it's far too soon to say that signing the memorandum of agreement has totally changed the landscape, let's wait and see.
Diary Entry 11

The term 'independent midwife' was used throughout the interviews with obstetricians, pointing to where their concerns lay – in the 'independence'.¹⁰¹ In their perceptions of home birth and of in-labour transfer, these obstetricians were opposed to a midwife offering care to women who was 'alone', working outside the governance structures of the maternity hospitals.¹⁰² The most disabling influence to emerge from the interviews with obstetricians stemmed from their interactions with 'Independent Midwives' in the 1990s and before. Their narratives referred to specific historical cases that they identified as examples of "very poor care" (Triona, Obs). The obstetricians acknowledged that, even when they had not been personally involved, these cases and their legacy had an impact on their perceptions of home birth and of the SECMs.

Sheena (Obs):

We've had some bad ones, you know, we've had people who've been three hours in the second stage of labour, we've even had people who've supposedly been three hours in the second stage of labour who aren't fully dilated when they arrive in. And we've had some sick babies ... so you become wary of what they are actually doing out there ...

These obstetricians were either unaware of the governance structures in place within the MOU or did not feel that they went far enough in regulating and governing midwifery practice and home birth. ^{Fieldnote 12}

¹⁰¹ All of the midwifery facilitators of home birth referred to themselves as an SECM. The term 'independent midwife' has been phased out of use by these midwives since the advent of the MOU.

¹⁰² This objection was mentioned in Section 7.3.2 when identifying the conditions under which obstetricians would support home birth.

Eileen, (Obs):

So it's not a good idea to have people working stand-alone. They need, from a professional development point of view, from a 'keeping current' point of view, from working within protocols and guidelines point of view – there needs to be some sort of oversight, there needs to be a governance structure, and they need to be working with colleagues. And I think the current system doesn't provide for that ... the MOU ... I suppose my anecdotal experience of the system so far, I think that – and I'm only talking about a small number of cases – but it probably is not good enough or [going] far enough to regulating the practice of these midwives.

In an attempt to offer a solution to what they understood as *the* problem with home birth and transfer, the obstetricians suggested that the supervision of SECMs should be undertaken by the “*local governance structures already in place*” (Sheena, Obs), to ensure that their practice was in line with the policies and guidelines of the maternity hospital.

Eileen, (Obs):

I think the answer to it is, is for all of the midwives that are providing this home delivery service to be registered with, reporting into, and responsible to a host institution – that they report their figures into, that they audit their practice, that they for X number of weeks a year they come in and they work within the service,¹⁰³ they keep up to date with everything that they need to keep up to date with, and that they show that their practice is compliant with guidelines and protocols and that their service is compliant with what one would expect, standards that one would expect.

The suggestion that SECMs should align their practice in accordance with hospital-based policies was put forward by three of the obstetricians, with little regard for the understanding of birth held by SECMs or the current critique of birth in hospital.¹⁰⁴ This, obviously, was a stance that the SECMs encountered; they stated that obstetricians, in general, believe that obstetric-

¹⁰³ This was also suggested by five hospital midwives as a way to provide continuity of care across the home-hospital continuum, keeping understanding of birth uniform and in keeping with the dominant discourse of obstetrics.

¹⁰⁴ Entries to my diary during analysis of this data reveal my belief that the obstetricians were not completely familiar with the terms and conditions of the MOU and how this influenced the provision of care at home.

led protocols should guide midwifery practice. This raised disquiet among the SECMs; they proposed that such an approach was not appropriate for normal birth. They stated that this made them vulnerable and open to “*professional condemnation*” (Caoimhe, SECM).^{Fieldnote 13} (See discussion at Section 7.3.3).

8.6.2 ‘The barriers go up’

The SECMs⁽ⁿ⁼¹⁰⁾ commented on the doubts the hospital practitioners held and suggested that it was evident in the way the HMWs interacted with them during the initial meeting in hospital. SECMs commented on the “*lack of interaction*” (Enora, SECM) in that the SECMs perceived that they were being both ignored and judged as the “*hospital got on with it, not including you in anything and just make you feel like they were so busy sorting it all out*” (Enora, SECM). In these initial communications SECMs did not make reference to obstetricians; this seemed to be for two reasons. First, the HMW was always the first person they met on arrival at hospital; the ‘triage’¹⁰⁵ if you will. Second, obstetric involvement during the initial stages in hospital only occurred with emergencies, with little time for interactions that were not focused on dealing with the urgent situation.

SECMs reacted to this ‘disregard’ in different ways. Some⁽ⁿ⁼⁵⁾ suggested that it was not acceptable; others labelled it as disrespectful. However, all the SECMs agreed that it had the potential to set the tone for the subsequent experiences, and this was not a supportive environment for them or for women (women who, in general, held their SECM and the care she provided in high esteem).

Caitriona (SECM):

I would accept the fact of different opinions but I often found it surprising that there was that animosity towards us. It's almost as if they were too busy to engage with us and too important to ask us our opinion. And I genuinely would consider it animosity because that is the way it felt and I'm sure the women noticed it. It wasn't really a good start to the transfer for anyone having that kind of carry-on.

¹⁰⁵ Women's needs were assessed by midwives and then the appropriate practitioners were called to offer care.

The SECMs suggested that confrontation in these situations was not appropriate. Although the experiences of the obstetricians and some of the HMWs would not reflect this, in these moments SECMs believed that they should ignore negative interactions rather than react to or challenge them, thus “*making the situation worse for everyone*” (Eimear, SECM).

Maeve (SECM):

I see the looks, the remarks, but I don't pass any heed. I pretend that I don't notice what is going on. I am just so pleasant and I chip away slowly, slowly getting people on my side, wearing down the barriers they have put up.

Some of the SECMs⁽ⁿ⁼⁷⁾ alluded to “*putting up*” (Siofra, SECM) with this disregard in order to avoid an argumentative ‘handover’¹⁰⁶ in the hope that the women would experience a smooth transition to hospital-based care.

8.7 ‘Handover’

The experiences of in-labour transfer most vividly recalled by midwives (SECMs and HMWs) in this study focused on the time of ‘handover’ when the women arrived at hospital and plans for care were made (or in some cases dictated). SECMs considered this a significant stage in their experiences; they stated that it was at handover they were most acutely aware of being accepted or dismissed by HMWs. It was during these interactions that HMWs ‘allowed’¹⁰⁷ the SECMs to stay and support the woman or not. The logistics of transfer are described as challenging; SECMs⁽ⁿ⁼⁷⁾ described how the processes varied in the hospitals.

Siofra (SECM):

... in some hospitals you hand over in a triage-type unit and the midwife you speak to there may not be the midwife looking after your woman, which isn't great. In other hospitals you are allowed into the labour ward until everything is settled and in

¹⁰⁶ In this context, all the healthcare participants in this study used the word ‘handover’ to denote the verbal communication of the woman’s history in relation to pregnancy and labour, and of the lead-up to and the reason for transfer. Some of the hospital-based midwives considered this to be the point when they assumed “*responsibility for that woman’s care*” (Fiona, HMW).

¹⁰⁷ Word used by five of the seven women who had the support of their SECM during the time in hospital.

other places, depending who is on, you might be able to stay. You rarely get to hand over to a doctor, which would make a lot of sense if they are involved in caring for this woman.

The SECMs questioned not having the opportunity to discuss the woman's history, the care given to her thus far, and the reasons for transfer with the specific healthcare professional taking over her care. They felt that this *handover by proxy* made it difficult to preserve any continuity of the plan of care for the woman.

The function of the handover was seen differently by the different participant groups; women¹⁰⁸ and SECMs hoped that it would be a time to negotiate a pathway to meet the woman's needs. Many of the HMWs⁽ⁿ⁼⁹⁾ viewed it as the point when they established the facts of the transfer as they "*took over the management of the woman's labour*" (Dervla, HMW).

8.7.1 'I just wanted to find out what happened'

When describing their experiences of handover, some of the HMWs⁽ⁿ⁼⁹⁾ talked of brief communications. In these encounters these midwives "*just wanted to establish what was going on*" (Isla, SECM).

Mona, (HMW):

We didn't have much of a conversation really, you know, I just needed to get the details from her – you know when the woman went into labour, how dilated she was, that kind of thing.

Dara, (HMW):

Well, the woman was in a lot of pain when she came in so there wasn't much time for handover before the SECM left. I needed to sort her out, get the epidural ... I had a grasp of what was going on when she'd last been examined ... so I just took it from there.

HMWs⁽ⁿ⁼⁵⁾ did not always remember the name of the SECM; in fact two had to stop and think before they could recollect if an SECM had accompanied the women into the hospital or not. They suggested that the

¹⁰⁸ Five of the women said that they had no memory of the interactions at the point of handover; they were distracted with contractions at this stage.

handover had left little impression on them: “*I just wanted to get on with it, really*” (Clair, HMW).

As regards their attempts to ascertain the woman’s history and gain an insight into events prior to transfer, four of the midwives were very critical of the handover they received from the SECMs.

Myrna, (HMW):

... our biggest issue, we didn’t have accurate times and that was kind of quite vague until I suppose maybe afterwards ... I know at the time she probably hadn’t her notes, until she kind of sat down and looked at things so that was a bit vague, it was quite frustrating.

These midwives considered the SECMs’ documentation skills to be poor and suggested that this made it challenging when planning care for the woman. This alleged lack of clarity led to further doubts in relation to the SECM, in that the midwives began to question the systematic thought process underpinning the SECM’s practice. ^{Fieldnote 14}

Piala, (HMW):

... poor document, poor recall of times, and this made it difficult to figure out when she was fully, what had been going on during that time, you know what she had actually been doing to try and sort this out

Two of the midwives were very concerned about the handover they had received from one of the SECMs. They suggested that the information was not offered in a way that provided a clear picture of events prior to transfer. Demonstrating the mistrust involved in this interaction, the midwives told how they had “*made sure*” that the SECM documented the points of her verbal handover in “*our notes*” (Piala, HMW).

Alva, (HMW):

... so we got her to write it down again, in our hospital notes, exactly what happened and to sign it. ‘Cause we were not clear from what she had said ... and you know, if anything happened afterwards at least we had it all documented ...

Mistrust and suspicion were apparent in many experiences at the interface of home and hospital birth, and were raised by all the participant groups. However, this was the only specific example raised that indicated concerns over an individual's practice.¹⁰⁹

The time given to handover was deemed appropriate by this group of hospital-based midwives⁽ⁿ⁼⁹⁾. SECMs recalling similar situations¹¹⁰ described their interpretation during handover as a "*rapid judgement of measurements without any consideration of what went on before and why*" (Leah, SECM).

8.7.2 Judge and Jury

Section 8.4.2 drew attention to the SECMs' concerns that decisions they made during labour and preceding transfer would be questioned by hospital-based staff. The narratives of 12 SECMs referred to a feeling of being judged. The SECMs identified both subtle and obvious approaches that they perceived the HMWs to employ. Some of the SECMs felt "*judged before you even open your mouth*" (Eimear, SECM); they suggested that disapproval was evident in their initial interactions with HMWs and the manner in which they were dismissed. Others sensed disapproval in the questions midwives asked and in their reactions to the answers.

Enora, (SECM):

... it's like a quickfire judgement, "How long has this mother been in labour? When did her waters go? What time? Hey, that's nearly 24 hours", and judgement calls are made: "You've left this woman so long, what were you doing?", without even looking first and seeing that all is well with her and with her baby.

The SECMs⁽ⁿ⁼¹⁰⁾ described experiences where midwives openly challenged the care they provided: "*why didn't you – ... come into hospital sooner ... do another VE ... follow the [hospital] guidelines ... fast her ... assume there was meconium?*" (Enora, Enya, Naoise, Eimear, Maeve - SECMs).

¹⁰⁹ Outside the interview, I asked these two midwives if they thought that this was an incident that needed to be referred to the appropriate midwifery manager for review. This process had already been instigated by these midwives.

¹¹⁰ The SECMs were not necessarily recalling the same cases.

Caitriona made reference to the questioning tone that made her feel like she had done something awful, which, in her view, was accompanied by facial expressions of “*eyebrows raised and lips pursed*”. Repeatedly, the SECMs stated that deviation from the guidelines of active management of labour (assessment of cervical dilatation, hours in labour) caused the most concern for HMWs.

Leah, (SECM):

It's the questions – “so you did a VE, at what time, and what was the one 2 hours before that?”, and you just want to scream “there was no reason to do one 2 hours before that”, and I know, I understand, I have worked in hospitals, I know what happens but God it is so frustrating.

During these experiences the SECMs felt that their practice was being benchmarked against an understanding of birth and midwifery practice informed by an obstetric model of care.

8.7.2.1 ‘They think I’m risky’

The SECMs⁽ⁿ⁼¹⁰⁾ believed that in these moments the hospital staff viewed them as “*risky and dangerous*” (Naoise, SECM). None of the hospital-based practitioners used this specific expression, yet many of them (as referenced throughout Chapters 7 and 8) indicated that they associated home birth with poor outcomes and anticipated the worst regarding transfer. SECMs were aware of this and suggested that transfer magnifies any misgivings that hospital-based practitioners hold in relation to birth outside hospital.

Rosa (SECM):

They [hospital midwives] think you are outside the barrier or whatever. You aren't just pushing the boundaries, you are outside them. You've decided on a pathway that is considered 'risky' and you must be ignoring the risks if you are prepared to be outside the hospital system.

These SECMs stated that HMWs gave them the impression that transfer confirmed all their “*suspensions in relation to us and everything to do with home birth*” (Leah, SECM). With a self-deprecating tone, Caoimhe

(SECM) proposed: “they thought we were dodgy anyway and now they think that we have proved them right.”

Some of the HMWs⁽ⁿ⁼⁸⁾ narratives concurred with the SECMs’ interpretations in that they allowed that “we¹¹¹ have a different point of reference” (Dara, HMW). These midwives suggested that their understanding of birth and critiques of transfer were informed by their immersion in hospital birth, with little exposure to anything else.

Saoirse, (HMW):

In some ways I think it's always a bit of an unfair situation [transfer] because everything in obstetrics is outcome-driven. You know, if you had a scenario where you might say 'well, she's 9cms for 5 hours' I might be a bit surprised because I'm unlikely to see that in a general fashion here [in hospital]. But in a home birth context that is feasible and the pains may have gone, the fetal heart was fine and you are waiting for her to have a bit of a sleep and then the pains will come back. And I know that, I understand that. But everything in hospitals is outcome-driven and it is only the right thing to have done if the baby and the mother are fine following the event ... so if you've to come in here [the hospital] because the pains didn't come back after the sleep then that's a different story. That's the problem isn't it and then all we [hospital-based midwives] see is the hours of doing nothing before you came in...

They maintained that this was a shortcoming of the maternity services in Ireland and something over which they personally held little control.

Helen, (HMW):

... this is just the way we [HMWs] think, what we know is all based on what happens in hospitals, that is what we live and how can it be any different when that is what we gauge as normal ... we are not going to change that overnight.

The data from the interviews with these HMWs⁽ⁿ⁼⁸⁾ reveal that they were aware of their critical attitudes underpinning their interactions at transfer.

¹¹¹ ‘We’ was always used in these narratives, never ‘I’.

Mary, (HMW):

It can be awful, the atmosphere ... the way the SECM is criticised. Like who are we to judge, it's not like we are out there doing it?

SECMs articulated the frustration they experienced during the encounters, where aspersions were cast on the care they provided during home birth. They tried to rationalise “*why other midwives are so critical of all things midwifery*” (Naoise, SECM).

8.7.2.2 ‘They don’t understand’

Janet, (SECM):

... they don’t see normal home birth, they know nothing about it and they don’t really believe that it can happen outside the hospital, well, that it can happen safely.

In an attempt to make sense of the interactions involving doubt and mistrust, the SECMs⁽ⁿ⁼¹²⁾ suggested that the HMWs “*did not understand home birth*” (Isla, SECM). Two reasons were offered to support this position. The SECMs reiterated the point acknowledged openly by the HMWs and doctors that their exposure to home birth, for the most part, focused on scenarios when the planned route of a spontaneous vaginal birth at home was not realised (Section 7.3.2). They also drew attention to midwifery narratives imbued with an obstetric understanding of birth. Some of the SECMs⁽ⁿ⁼⁵⁾ even went as far as to suggest that midwives in hospital had “*forgotten normal birth outside the tight parameters set by the clock and regular VEs*” (Siofra, SECM).¹¹²

Bridget, (SECM):

They don’t see what went on before, how we got to here, what we have done ... they just see something that needs sorting.

Caitriona, (SECM):

... just an assumption that it all went pear-shaped and we caused it or that we didn’t do anything to sort it out.

¹¹² An assertion that would not be denied by some of the HMWs in this study.

The SECMs suggested that HMWs (and obstetricians) often based their judgments on the reason for transfer, viewing facts “*in isolation*” (Enora, SECM) rather than taking into consideration the totality of the experience. “*Meconium ... delay ... stuck at 7cms ... twenty something hours ... words bandied around*” (Janet, SECM), with, the SECMs suggested, little reference to the context in which these issues emerged.

Enya, (SECM):

... and the biggest problem for me is the way it all gets lost ... you hand over to the midwife and she has to do her admission paperwork and then someone else comes in and then someone else phones an obstetrician and all they hear is ‘2½ hours pushing’ or whatever it is and everything else gets lost in translation ... the need to get the whole story.

During the fieldwork, I heard and saw examples that indicated clearly that background story and pre-transfer care were ignored in the face of the most immediate current situation.¹¹³ In these moments the hospital-based staff focused on specific forms of assessment and surveillance that they deemed measurable.

8.7.2.3 ‘We do things differently here’

In my observations of in-labour transfer, I was exposed to interactions at handover that support the findings noted in Section 7.3. Different readings of birth were apparent and ongoing care was based, for the most part, on routine surveillance and intervention.

Ailis and Bridget (SECM), (observation during in-labour transfer):

The SECM was well known to the hospital midwives, they all greeted her by name and she just went into the room with Ailis and Malachy, no fuss made. I was directed to wait by the big desk, the central area of the labour ward. This was where Attracta, the midwife-in-charge, held court, watching and directing the activity of the ward, midwives coming out of

¹¹³ Reflections from my diary indicate that I can relate to both versions of events: the SECM who feels judged because the HMWs are focusing on the length of a woman’s labour, a figure, with little reference to the care during labour or maternal and fetal wellbeing, but also (to some extent) the HMWs who feel a sense of urgency when a transfer presents to their practice.

rooms updating her on what was going on – “not in labour ... up and walking around ... pains getting stronger ... looking for an epidural ... syntocinon started ... fully an hour now ... get her reviewed ... ready for the ward”.

... a registrar in obstetrics was phoned, asked to come and review Ailis and her case, Attracta told me “Louise [doctor] will do a VE now in a minute and we’ll see what is going on, we do things differently here Linda, we’ll have to get her moving along and get this baby out”.

Louise did a VE and decided to do a FBS [I discussed this afterwards with Bridget], Bridget assumed it was because she was not confident re the handover that the fetal heart had been intermittently osculated and fine before the recorded incidents. The results of the FBS were held as being very reassuring. Attracta filled me in, “7cms dilated, bit to go yet ... we aren’t as generous here as some with VEs, she’s starting synto but wants an epidural first, Bridget is going to stay with her”.

I spoke with Bridget after the birth of Ailis’ baby. We discussed my observations and interpretations and her experience.

Bridget, (SECM):

... it was fine Linda, I mean I didn’t really expect it to be any different, I’ve been here before you know, I know how to handle it at this stage. I was there, I got to support Ailis, I was able to influence the plan of care and help Ailis work through the hospital stuff, you know, the syntocinon and that. I wouldn’t have been able to do that if I was here making a big fuss when I arrived, getting their backs up. If they asked me to leave what good would I have been to Ailis then? ... of course some things are grating, their queries of your handover, some of their policies, but you pick your battles and work away in the background, making little suggestions, offering supports and think ‘what will help this woman in the grand scheme of things?’

Things may ‘*be done differently*’ (as noted by the HMWs) in hospital, however, I heard and saw forms of resistance by the SECMs to the norms of hospital care, they were forms of resistance that I had not anticipated. ¹¹⁴
The SECMs⁽ⁿ⁼¹²⁾ who participated in this study suggested that, when

¹¹⁴ From my early interactions during fieldwork, I observed that SECMs were not easily swayed (Section 6. 6.1). An entry to my diary demonstrates that I anticipated that the SECMs would be openly challenging in their dealings with hospital-based practitioners. I had not expected subtle manoeuvring.

possible, a non-confrontational interaction secured their presence in the labour ward (and sometime even in the room), thus enabling them to continue to contribute (albeit subtly) to women's care.

Siofra, (SECM):

This is not the time [at transfer] to take on the system, no, this is the time to make sure it is as good as it can be for this woman. I'd worry that going in there being awkward or, you know, shouting the odds, it just won't work ... and then you have the woman stuck in the middle of all of that.

Leah, (SECM):

... we come in for a reason, we have to remember that and it's often because interventions are needed ... if they see you as reasonable during this interaction you are setting the groundwork and then it makes it easier to question something you think is not warranted.

The moments of conflict exposed in the obstetricians' experiences¹¹⁵ do not concur with these narratives. The postmodern reading of multiple understandings of reality helps me make sense of this; however, the contrast between these SECMs' intentions and the obstetricians' experiences may be particular to the participants of this study.

While some HMWs⁽ⁿ⁼⁸⁾ were aware¹¹⁶ of the limitations associated with their immersion in hospital birth, with little exposure to other models of maternity care, others⁽ⁿ⁼⁹⁾ rejected the idea that this placed them in a position where they were unable to support normal birth. During their interactions with women and with SECMs, these midwives believed their ability to offer midwifery support and to facilitate normal birth was called into question. In these experiences, similar to SECMs' interpretation of how they were perceived at transfer, hospital-based midwives felt "judged" and their practice challenged (Fiona, HMW). Aware of this judgment from their initial interactions at transfer, midwives suggested that, in their view, this made their experiences strained, unpleasant and certainly not positive.

¹¹⁵ Section 8.8.2

¹¹⁶ Three of these were actually apologetic about this.

Dervla, (HMW):

... she [the woman] barely even talked to me, it was as if she sort of felt I couldn't help her, it was like I didn't understand that her plans had changed or I wouldn't get what she was talking about, so she didn't ask me anything, she directed all her questions to her midwife [SECM]. It was very hard, I think that's why I remember it so well because I felt out of place, I didn't feel the way I usually do when I'm in work. I was doing my best to try and meet her needs given that things had changed ... I wasn't stopping her from having a normal birth, it was just the way that things had changed.

The HMWs sensed that some women did not trust their willingness or ability to maintain any element of normality in their experiences of birth (as noted in Sections of 8.10, this was a concern raised by the women). This was viewed as an unfair assumption by HMWs⁽ⁿ⁼⁹⁾ in this study and was seen to widen the divide between home and hospital birth before SECMs had the opportunity to “*show them what we can do, show them that we are not all about intervention and sections*” (Piala, HMW).¹¹⁷

In the same way that obstetricians offered suggestions to overcome the challenges they perceived in-labour transfer (Section 8.9), HMWs suggested that all hospitals should provide a DOMINO service. In this model, the commitment to midwife-led care was seen as an endorsement that “*the midwives in this hospital do support normal birth*” (Catherine, HMW). These HMWs were genuine in their belief that they support and facilitate normal birth. However, my reading of some of their stories in relation to transfer indicates that their support of normal birth may occur in the context of surveillance, regulated time-frames and protocols informed by obstetric constructions of birth and risk. My observations of the labour ward concluded that the medicalisation of birth permeated every corner of the rooms, in a highly visible way.¹¹⁸ The profound impact of the culture on

¹¹⁷ This provides another example of midwives across the participant groups suggesting that negative assumptions are made about the midwifery care they offer. Section 8.7.2 highlights data from the interviews with SECMs that demonstrates that they feel ‘written off’ by hospital-based practitioners – “*judged before you even open your mouth*” (Eimear, SECM).

¹¹⁸ Section 8.2 referred to the clearly visible accoutrements of medicalised birth in the labour wards. All the accompaniments to ARM, IV infusions, augmentation of labour, sterile procedures, instrumental birth, instruments, suturing materials stacked neatly on

defining (and redefining) normal birth was highly evident not only in the attitudes and behaviour of hospital staff, and in the treatment of the women and SECMS, but also in the physical environment and accoutrements of the labour wards.

Little was offered by the HMWs to explain why women currently did not trust their rhetoric of supporting normal birth or even believe that this was possible within the current provision of hospital-based midwifery care (Sections 7.2.1.3, 8.10.3).¹¹⁹ The critique of in-labour transfer presented by these HMWs focused on their perceptions of women's views of hospital care and women's expectations in relation to birth. The HMWs offered little or no challenge to the current provision of maternity care in hospitals in Ireland.

8.7.3 A Seamless Meeting

Lana and Bridget (SECM), (observation during in-labour transfer):

... we arrived in with Lana and it was bedlam, a midwife dashing with a portable ultrasound machine, opening of theatre, bleeps going off, doctors rushing down the long corridor and in the middle of it all Lana crying out, Bridget at her side the whole time as they went into the room – and suddenly I was sitting, someone had rolled a chair underneath me and tea was placed in my hand and Saoirse [midwife in charge] passed me en route down the corridor, turning back to say – “It’ll be fine, Linda, let’s just see what Bridget needs.”

The interactions at handover were not always grounded in suspicion and mistrust. All the SECMS spoke of at least one experience they had when

rows of shelves (usually on shelves not inside a press with a door); beds always the centre of the room, medical beds that could move up and down and have accessories attached (e.g. drip stands, stirrups). The other focal point in the room was a resuscitation table, attached to oxygen to suction points. All rooms had clocks, some even had two (big old-fashioned clocks, the ones I remembered from examination halls in the 1990s!).

¹¹⁹ In my observations of labour ward and delivery rooms (as the midwives referred to them), I tried to see anew their layout, what was in them, the message that they conveyed to labouring women. I made an effort to do this given that I have spent some time working in such an environment and risked being desensitised. When planning home birth, women spoke of the physical environment they desired, and what they deemed important. In recalling their experiences of transfer, not one woman made reference to the physical environment of the hospital room. Their narratives focused on the way they had been treated by hospital staff and the extent to which they had been included in the decision-making process.

transfer was “smooth” (Caoimhe), “seamless” (Enora), or “supportive” (Caitriona). During these encounters SECMs felt “respected” (Enya) and “understood” (Eimear). In these moments the SECMs suggested that “the woman came first” (Leah), “everyone left their egos aside and we just got on with it” (Maeve), “there was no sniping at each other” (Rosa), “they know me, I know them and we all worked together for this woman” (Janet). The SECMs declared that these scenarios were not predictable because they were dependent on “who you happen to meet” (Naoise). I observed during transfer and heard from the SECMs stories that these positive experiences often rested on the understanding of birth, opinion of home birth (and of the SECM) held by the most senior midwife on the labour ward. In their role as co-ordinator they set the tone of the ‘shift’ and the other midwives seemed to follow the example set.¹²⁰ (The SECMs did not see this influence extended to the interactions with obstetricians.)

Bridget (SECM) and Saoirse (HMW), (observation after in-labour transfer):

All was done, the baby was feeding and Lana and Jonathan were gazing at her. Bridget and I were leaving the labour ward ... I was drained after it all and Bridget looked pale and tired. Passing by the desk where the midwives gathered, Saoirse [midwife in charge] called out to us to see if we were ok. She said “I think we all did good” and so ensued one of those spontaneous chats reflecting on care that colleagues often have ... she and Bridget hugged and it just seemed like the natural thing for 2 midwives to do after a long and emotional day supporting a woman to birth. The other midwives there said goodbye, one took Bridget’s mobile number so she could phone her if Lana wanted her for anything.

Experiences demonstrating collegial interactions were held by the SECMs as examples of an integrated maternity service, in which a seamless interface between home and hospital birth facilitated the needs of the women.

¹²⁰ My reflection on this during data analysis brought me back to my days as a junior midwife scanning the off-duty before *nights* and hoping I was on with midwifery sister x and not midwifery sister y. With sister x I knew the week would be great, with sister y it would be stressful, with ARMs and continuous monitoring the order of the day.

Ciara, (SECM):

It's the way it should be, isn't it, us all working together ... I mean that is why we all do what we do ... we all want happy and healthy women and babies so what is the big deal about working together to ensure that is what happens?

The initial interactions between the SECMs and hospital midwives and the judgements made during handover set the scene for any ongoing interactions during the experiences.

Postscript from Fieldnotes: Maude (HMW), (observation):

I was sitting at the so-coined 'nurses station' waiting for Bridget to come and tell me what was happening, Maude [midwife] was sitting beside me putting together an admission chart for Lana. She turned and asked "a multip, sure what is she doing coming in here, why didn't she just have her baby at home?" In the middle of all that was going on and in spite of myself I smiled and thought 'you just can't win!'

8.8 'To be there or not to be there'

During transfer, some of the SECMs were 'allowed'¹²¹ to stay with the woman in hospital for the remainder of her labour and birth experience. This was the case for seven of the women in this study.¹²² Six of the SECMs noted that they had never stayed with women once care had been handed over to hospital staff. The other nine SECMs had experiences of both (remaining with women and having to leave the labour ward). The mandate 'stay or go' formed part of a negotiation in some cases; for others, there was no room for dialogue, and they were instructed to leave (Section 8.6).

¹²¹ The word 'allowed' has been used deliberately as in the culture and context of birth in Ireland it is not a given that the SECM will remain with women after transfer. It remains, for the most part, an *ad hoc* arrangement based on some of the issues discussed in Section 8.6 and 8.7 (e.g. the preference of the hospital-based midwife, the reputation of the SECM, the tone of initial interactions at transfer).

¹²² Seven women had their SECM with them during their experience of birth. For three women, their SECM waited outside the labour ward, remaining in the hospital. In 13 cases, the SECM was asked to leave or not allowed to stay. (Two women were not accompanied by their SECM on arrival at hospital; verbal handovers were communicated to hospital staff via telephone.)

Clíodhna, (SECM):

... the midwife was obviously expecting me to leave straightaway and she said it a few times, "you can go now, I'll take over here" ... and when x was settled and I was going the midwife came out of the room after me and apologised, said her hands were tied, that it was hospital policy or something.

Eimear, (SECM):

... it depended on which midwife you were dealing with ... some let you stay, others can't get you out the door quickly enough.

As with many of the findings explored in the previous section, 'depending on who you met' influenced the implementation of hospital policy. Being asked to leave, or not being allowed to stay, contributed to the SECMs' perceptions that hospital-based midwives were suspicious of them and/or placed little value on their midwifery practice and their relationship with the women.

Caitriona, (SECM):

... in that hospital you'd pretty well be almost blocked from going into the room with the woman ... I was told "you can leave now, we don't allow ..." ... when you wanted to accompany the women into the labour ward it became evident you had no status at all within the hospital or with the midwives there.

During my time in the field, it became apparent that certain SECMs were regularly permitted to remain in certain hospitals after transfer. I understood this in the light of the SECMs' claims that being known to the hospital staff made a difference to the way they were treated. I also made sense of it against a background of hospital-based midwives basing their expectations and interactions at transfer on the reputation of SECMs.

The presence of the SECM until after the birth of the baby was viewed very positively by the women in this study. They believed that having the SECM there "kept me safe, the SECM kept a watchful eye on everything" (Rona). Many⁽ⁿ⁼⁹⁾ who did not have this option proposed that it would have facilitated a positive experience. For the midwives (SECMs and HMWs) the experiences of staying were not always so straightforward.

8.8.1 'I'm still her midwife, you know'

The SECMs suggested that the advantages connected with their ongoing presence in hospital outweighed any disadvantages. For the most part they drew attention to the continuity of care it offered to women, noting that this was one of the reasons women choose home birth in the first place: "*I am still her midwife you know, that shouldn't end*" (Leah, SECM).

Rosa, (SECM):

I see complete sense in me staying with the woman, I mean I know her, I've provided her care up to that point, I know what her plans were, what she wanted, what she hoped not to have. It makes no sense to banish me in the middle of someone's labour, it doesn't matter where they are.

The SECMs believed that asking them to leave added to any stress that women may already have been experiencing as a result of their transfer.

Naoise, (SECM):

... so this woman's plans are being messed up. Things aren't going the way that she thought they would and then the one midwife she knows is expected to leave. It's very tough for the woman and the SECM.

Some of the HMWs⁽ⁿ⁼¹¹⁾ also raised this issue and saw the merits of the SECMs staying with women and the important impact it could have on the woman's experience of birth.

Mary, (HMW):

I've always had a huge difficulty with the independent midwives not being allowed in. They are all midwives too; we have a job to do together.

The SECMs' narratives focused on the woman, her needs and the benefits of continuing the long-established professional relationship. HMWs did raise these supports, but their accounts also made reference to roles and

professional responsibility: “*Who would do what?*” (Fiona, HMW ^{Fieldnote 15}).¹²³

8.8.2 ‘Caught in the middle’

“*Transferring with the women*” was not without challenge for both groups of midwives. The midwives drew attention to the contested professional boundaries experienced at the interface of home and hospital birth. This stemmed from the position of the SECMs in the new pathway of care. In the current organisation of maternity services in Ireland, the role of the SECM following transfer to hospital is that of a ‘support’ person. All the SECMs in this study said that it was unusual for them to have an active part in decisions regarding the woman’s care outside that of support. This was not actively contested by SECMs at the time of transfer,¹²⁴ but was something that they ⁽ⁿ⁼¹⁰⁾ suggested warranted exploration. Only one of the 11 HMWs who raised the issue of SECMs remaining with the women advocated the SECMs continuing as *the* midwife in this situation.

During the interviews, these HMWs ^(10 out of 11) differentiated between the role of ‘*a support person*’ and ‘*a midwife*’. Over half ⁽ⁿ⁼⁷⁾ used the phrase ‘*like a doula*’ to describe their vision for the SECM while they (hospital-based midwives) would “*still be responsible for all the midwifery things going on*” (Dervla). The ‘other things’ related to “*assessments*” (Myrna), “*monitoring*” (Clair), “*decisions*” (Alva) and “*managing labour*”, an expression repeatedly used. This was a delineation of midwifery that I had not expected; in my understanding midwifery is an indestructible amalgamation of both support and midwifery. ^{Diary Entry 16}

¹²³ The obstetricians in this study made reference to some women wanting the SECM to stay after handover. They did not view this as an appropriate option for care. Concerns such as “*they don’t know our policies*” (Eileen, Obs), “*it would be too confusing for women, how could you have 2 midwives there?*” (Brenda, Obs) were raised.

¹²⁴ Four of the SECMs said that they definitely would not challenge the fact that they were not acknowledged in the planning of care. They considered their presence in the labour wards as a radical improvement compared to their previous experiences of being asked to leave. These midwives suggested that incremental changes would follow in relation to their role: “*Slow, it’s slow but as long as I am getting along they will see me in a different light and before you know it I will be involved in a lot more*” (Maeve, SECM).

It was also suggested that the SECMs could be influential in bridging any gaps between them and the women.¹²⁵

Iseult, (HMW):

It's actually quite difficult because the person who has been with the patient all through labour is gone, and when you take over they don't really trust you in the first instance ...you need the help of the other midwife to explain and tell the patient what we need to do.

It was assumed that SECMs would explain why an intervention might be necessary and that birth plans needed to be adapted to coincide with the new direction of their labour.

Not all the experiences emerged as positive; some of the midwives⁽ⁿ⁼⁹⁾ regarded the presence of the SECM as a “*double-edged sword*” (Piala, HMW). They suggested that tensions were caused by different views on “*the way I needed to manage the care*” (Teegan, HMW). Midwives felt that the women looked to their own midwife for guidance, and the opinion of the SECM did not always tally with the local guidelines and policies.

Fiona, (HMW):

But then she was standing at the side of the bed on a CTG and she wanted to get into the bath and the midwife [SECM] then said “maybe we can get you into the bath”. When I said “No, we can't do that at the moment” and when I explained the reasons for it, she sort of looked pleadingly at her own midwife and she was like “Maybe we can do intermittent auscultation?” And I then felt, I didn't know why she was suggesting intermittent auscultation considering there was Mec 1~2 draining and quite thick too. And the way the CTG had been? So I felt nearly I was being put on the spot to a certain extent, I found that difficult. It was as if the midwife was questioning, well, ‘why are you doing this, why can't she get into the bath, why can't she get into the shower, why does she need the CTG on at all?’ I found that really difficult.

In these cases, HMWs said they felt “*challenged and undermined*” (Mafra, HMW) and made it clear that any “*visitor*” (Clair, HMW) should know their

¹²⁵ The women also talked of moments when they looked to the SECM for advice when an aspect of care was presented to them by hospital staff (Section 8.10.3).

place in the organisation of care. SECMs were seen to question the care and also the knowledge guiding it. HMWs were surprised by these experiences and proposed that by transferring to hospital the SECM and woman had demonstrated a need for the hospital policies and protocols.

Clair, (HMW):

... everyone wants to work with everyone but what is the point in the SECMs coming in and then picking the bits they agree with and then the bits they don't. I mean, they came in for a reason, things are not normal now, so how can they start deciding that they only want some bits?

The HMWs recalled that any disagreements of opinion led them to involve an obstetrician (usually the most senior doctor): “we just call called the consultant to talk to the woman about what needed to be done” (Piala, HMW).¹²⁶

Some of these tensions were noticed by the SECMs; those⁽ⁿ⁼⁶⁾ with experiences of remaining with women after transfer at times “*felt caught in the middle*” (Enora, SECM) between women and other midwives.

Eimear, (SECM):

... you're in the middle of both of them. And she's [hospital midwife] saying “she needs an ARM” and the woman is looking at you going “but why do I need an ARM, I said I didn't want to have one”. And you see both sides ... so at this stage I ... am just honest with everyone ...

Even where there is a desire for collaboration, suspicion remains that the demarcation line as regards roles risks being crossed. SECMs state that in such situations they felt professionally vulnerable.

8.8.3 ‘Vulnerable, I feel vulnerable’

Previous sections of this chapter have explored the anxiety felt by some of the SECMs during transfer and their concerns about judgements made by

¹²⁶ Dervla (HMW): *... she didn't want oxytocin ... like the hospital is a completely different environment to home and she wasn't thinking about it like that ... but we had to get one of the consultants up to talk to her and then she agreed.*

hospital-based practitioners. No matter how appropriate they considered their care, SECMs⁽ⁿ⁼¹¹⁾ suggested that, when their midwifery practice was called into question, they felt vulnerable.

Janet, (SECM):

I talk to my friends who are midwives in hospitals, and tell them the goings-on [in relation to interactions at the time of transfer]. Some say I'm brave, others think I'm mad, I just feel so vulnerable.

Their vulnerability related not only to the way they were judged during inter-professional interactions at transfer, but also to the action that hospital-based practitioners¹²⁷ could take if they disagreed with the midwife's practice. SECMs spoke of their concerns that any critique was biased in that it was based on the medical model of maternity care and the guidelines associated with active management of labour. They suggested that any disagreements about their management of care could leave them open to accusations of professional misconduct.

Eimear, (SECM):

There is always blame attached and you are so vulnerable in this. You're dealing with a system that doesn't approve of home birth anyway so when the chips are down, their beliefs are confirmed and they are not shy in telling you. So while we are vulnerable and out there during home birth we are even more vulnerable and unsupported during transfer.

These SECMs all referred to the Fitness to Practice Committee of the Nursing & Midwifery Board of Ireland (NMBI) and the belief that "*they [obstetricians] will make a complaint, we have seen it happen before, and even if you've been found to have done nothing wrong the damage is then done, you are guilty until proven otherwise and even then it all sticks, it's horrific*" (Enora, SECM).

Naoise, (SECM):

I worry, I do. What if I transfer someone in, for a good reason, and then something happens – a poor outcome. Even if my practice was fine will they blame me 'cause I didn't do 2-hourly

¹²⁷ In these cases, the SECMs were referring primarily to obstetricians.

VEs or have a CTG or whatever ... they are not comparing like with like and they are not considering a labour that started out as a normal physiological labour and then something happened and then I did something about it – we transferred. No, they'll start judging me against routine hospital care and saying "this wouldn't have happened in hospital" and then I'll be hung out to dry.

Over the course of this study, several of the SECMs⁽ⁿ⁼⁷⁾ questioned their future as midwives facilitating home birth in the context of a maternity system that, overwhelmingly, supports hospital-based, obstetric-led maternity care.

Caoimhe, (SECM):

Is it worth it? Is it worth being labelled as dangerous? I am not a dangerous midwife; I am not a dangerous person. Is it worth having everything you do, the care you give challenged to the nth degree just because it is not tied to the medical management of labour? I am not sure that I can be like this, living on my wits and trying to anticipate the reactions of the hospital to everything I do before I do it. That is certainly not the mindset to have when you are caring for women.

The SECMs considered that obstetricians (and to a lesser extent HMWs) held the authoritative voice on issues of birth¹²⁸ and therefore were in a position to condemn midwifery practice as they saw fit. The SECMs identified a definite need to challenge this dominance; however, in specifying the approach this challenge should take the SECMs in this study suggested collaboration rather than confrontation.

Enya, (SECM):

We've seen what happens if you go in shouting the odds ... they have held the reins for too long, that approach isn't appreciated, you have to find other ways to change the system, you have to work with them, that's what will make it better for women and for us.

8.8.4 'Their world, their way'

Section 8.7 highlighted the subtle forms of resistance used by the SECMs in their attempts to remain with women in hospital and retain their influence

¹²⁸ That is, the authoritative voice in the eyes of the HSE, Department of Health and hospital structures.

on the ongoing care. This strategy may be interpreted as a way for the SECMs to find some level of acceptance in the world of hospital birth, to maintain their presence and to protect the principles of woman-centred care that these women wanted and had come to expect. The SECMs suggested that this approach emerged from their belief that there was little room to challenge the medical hegemony overtly, as, once they entered the hospital they had to “*do things their [obstetricians’] way*” (Maeve, SECM).

Leah, (SECM):

... and then she [obstetrician] just said “I am in charge now”. And I was like ... ok, Leah, back off a little here ‘cause no one is getting anywhere with this. And yes, I was annoyed, I knew Susan since the start of her pregnancy, I knew what she’d planned for her birth, I was there during the early hours of labour, it was as if none of this was relevant. But I knew I had to take a step back and just let them run it their way if there was any hope of me being able to do anything.

In their attempts to become accepted in the world of hospital birth, SECMs⁽ⁿ⁼⁷⁾ talked of the “*bridges I have built*” (Eimear), their efforts “*to change hospital-based practitioners’ opinions of SECMs*” (Leah), to make transfer a “*smooth and seamless*” experience (Bridget). Bridge-building took different forms and shapes; Enora mentioned her attendance at study days in the hospital with hospital-based staff so that “*they get to know me*”. Siofra¹²⁹ organised a meeting with women planning a home birth and midwifery managers in the local maternity hospital; the focus of the meeting was on formulating “*a birth plan if transfer is needed*”. Maeve talked of her attempts to “*show them when I transfer in that I am not cracked, that I am a safe practitioner, making informed decisions and now I am going to work with them because that’s what the woman now needs*”. Regardless of the specific approach taken by the SECMs in their seeking of acceptance, these midwives perceived that their entry into hospital birth was under the terms and conditions considered appropriate by hospital-based staff. In their constructions of hospital birth the SECMs were critical of the risk discourse and medical management that underpinned routines of care;

¹²⁹ Siofra was the only midwife in the study to facilitate such a meeting as part of antenatal care. This was something that the hospital-based midwives suggested would be a useful practice for all women planning a home birth.

however, in an attempt to become accepted by hospital-based staff, SECMs “*treaded carefully, yet purposefully*” (Enora) in their effort to negotiate interactions at transfer.

Janet, (SECM):

I've worked in hospitals ... I know what happens, I can figure the personalities; I quickly can tell who is going to listen to the woman and try and work with her as best as they can and who is just going to dive in doing their own thing. I know the drill and the routines. I know who is calling the shots and believe me I know that there is no point getting their back up because then they just go on supersensitive alert to everything you say and any wriggle room in relation to the woman's care will just go out the window.

The SECMs indicated that their perceptions of birth in hospital, of the controls therein and of the way they should act arose not only from their interactions at transfer but also from their experiences working within a hospital setting. The narratives of all the participants of this study left little doubt as to where they felt that the power and control was located.

8.9 ‘My jurisdiction, my responsibility’

The HMWs stipulated that SECMs must adhere to obstetric-led care if they remain in hospital with women after transfer. This position also featured in the narratives of the obstetricians, who assumed the mantle of “*lead professional*” (Brenda, Obs) once women entered the hospital system. None of the SECMs in this study argued this point; in spite of this, the hospital-based practitioners did not always report a harmonious experience in their interactions with women and SECMs.

As noted in Chapter 6, four obstetricians participated in this study, and their accounts ranged across experiences rather than focusing on one specific case. Section 8.6 noted how the obstetricians felt that their involvement at transfer centred on emergency care or when tensions around care occurred. They were often called by HMWs or junior doctors to intervene when women chose not to consent to certain aspects of care.

Eileen, (Obs):

As a consultant you only really get involved with the ones where decisions, difficult decisions need to be made, or where people aren't following the advice that is being given.

The SECMs suggested that these interactions set an antagonistic tone that was not ideal during the initial stages of care in hospital. The obstetricians acknowledged that, once interactions became tense; this permeated all aspects of the experience.¹³⁰

Triona, (Obs):

... if they're [women] disappointed, the doctor/patient relationship is kind of strained from the outset ... it's kind of like everything they didn't want for their birth and now all of a sudden you're playing a role in that ... it certainly puts a kind of a slight strain on the relationship at the outset.

The obstetricians proposed two reasons for the tension: (1) the SECMs' reading of birth and how this differed from the organisation of birth in hospital, and (2) women's expectations and knowledge of birth. The obstetricians did not disclose any thoughts they might have that they initiated or were the cause of friction. They indicated a steadfast belief that the care they offered in hospital was the "only course of management" in these scenarios (Triona, Obs).

Sheena, (Obs):

... they [SECMs] also have to realise that if they're transferring a patient then they're transferring the patient in for a good reason, whether it be for pain relief, whether it's for oxytocin, whether it's for fetal monitoring, and if they do that, you know, then we as a hospital have an obligation to look after that patient as we would for any other patient who's in the hospital – and that I think is the problem.

On several occasions the obstetricians noted that women transferred to hospital for a reason, a fact undisputed by SECMs. However, different opinions emerged in the discourses around women's specific care needs post-transfer or the level of intervention required. At the point of obstetric

¹³⁰ This was highlighted in some of the women's experiences; e.g. "as soon as I got there I knew the vibe was wrong ... and it all just went downhill from there" (Arlene).

involvement, there was a sense that little room for negotiation was allowed. Women felt that a rule of “*routine care for everyone*” (Arlene) was being applied. SECMs saw the obstetricians as “*not always taking into account women’s choice*” (Caoimhe, SECM), while the obstetricians considered these situations frustrating because “*they [women and SECMs] question what we know to be the safest thing*” (Triona, Obs). ^{Fieldnote 17}

Unlike the HMWs, the obstetricians viewed the presence of the SECM as unhelpful, and did not mention any benefits to the SECMs remaining with the women post-transfer. SECMs were seen to “*hinder*” (Brenda, Obs) the care, hospital-based practitioners’ interactions with women, and their ability to ensure that women agreed outright to “*appropriate and necessary management*” (Triona, Obs). While two of the doctors pointed out that this was not the case with all scenarios, it still remained a focal point of their interviews. The obstetricians had concerns about the ongoing role played by SECMs after transfer and the influence that they had on the choices that women made and the care they wanted (or did not want).

Eileen, (Obs):

Some of the SECMs will take a step back, because they recognise that they have no jurisdiction over what is happening now. And others think they still have a role. I think the patient looks to their SECM for advice as to what should happen in this situation. I think that causes friction.

In these interactions the hospital space emerged as the ‘obstetrician’s territory’; opinions they believed to be inappropriate were not considered as they assumed *the* professional responsibility for the wellbeing of the women and their babies. Although aware of the different understanding of birth held by SECMs, this was not deemed relevant to the care provided in hospital. The obstetricians held a sense of responsibility that outweighed any consideration of different beliefs in relation to birth. HMWs said “*we do things differently here*”, while obstetricians viewed care solely in the context of “*our guidelines and policies*” (Triona, Obs).

Sheena, (Obs):

But it's difficult for us to allow an independent midwife to come in and still continue to manage that patient here because she's now a hospital patient, we assume responsibility both legally, medically, according to our policies and there have been issues there where there's been a dichotomy between some of those.

All the obstetricians recalled instances of being abrupt with SECMs, justifying this by suggesting it was necessary in order to “*take control of the situation*” (Brenda, Obs). In this place of birth, the obstetricians suggested that they were in charge of the hospital services and therefore it was their responsibility to direct the route of care, especially when they thought safe care was being “*dismissed or refused*” (Sheena, Obs).¹³¹ While this contrasts greatly to the experiences of collaborating within women’s spaces (Section 8.2), these obstetricians believed their “*management of labour*” necessary to ensure “*good outcomes*” (Brenda, Obs).

Eileen, (Obs):

You either pull rank on the person [or] sometimes you've got to say “look, sorry, but you know this is no longer your case”, you know, it's like the US – the FBI and the cops, you know, this is not your jurisdiction ... which no one likes to do but sometimes it has been necessary.

As the findings in Section 8.8 demonstrate, professional boundaries were contested in these interactions, and the ongoing influence of SECMs was deemed counterproductive to “*expediting delivery*” (Eileen, Obs). None of the obstetricians divulged any doubt in relation to the decisions they made or the care they instigated, although they were aware that SECMs and women “*were not always happy about things*” (Sheena, Obs).

8.9.1 ‘Good cop, bad cop’

The women⁽ⁿ⁼²⁵⁾ in this study who experienced a transfer to hospital expressed their disappointment that their expectations had not been realised and their plans had changed. Their disappointment did not go unnoticed by the healthcare practitioners, but at times they suggested that the women’s

¹³¹ In these experiences continuous fetal monitoring, augmentation of labour and instrumental mode of birth caused the most controversy.

emotions were misplaced. The HMWs and obstetricians highlighted cases where they felt that women blamed them for the path their labour took and the elements of care they received. The obstetricians and HMWs (n=9) said that in these experiences they felt “mean” (Dara, HMW); “*she thinks I’m doing everything in my power to ruin her birth*” (Dervla, HMW); “*that I was saying ‘no’ to everything she wanted*” (Fiona, HMW). During scenarios where SECMs remained with the women, HMWs and obstetricians often felt that the women regarded ‘their midwife’ as “*the one on their side, the one they could turn to and trust*” (Catherine, HMW) while they felt women perceived them¹³² to be responsible for denying them choices.

Eileen, (Obs):

... it’s very difficult because you almost feel like that, in the hospital setting you’re almost portrayed as the bad cop – wanting to do something which nobody wants you to do. But you know that your job is to try and keep things as safe as they can be.

HMWs and doctors indicated that spoiling women’s plans was not their intention; they suggested that the basis for the care they proposed was to ensure the wellbeing of the women and their babies.

Tríona, (Obs):

You know, we’d rather stand back and everything to go smoothly but it’s very difficult if you have someone who doesn’t want us to intervene when we feel it’s the right thing based on evidence.

While hospital-based practitioners continuously mentioned ‘*the management needed*’, the women’s experiences demonstrated that their perceptions of their needs were not always informed by the same understanding of birth. Negotiating this ground was deemed challenging by all involved. Such experiences contrast greatly with those recalled at home when the decision to transfer was initiated by the SECM (Section 8.3.4). The trust that was apparent in those interactions, and the understanding and

¹³² When recalling their stories, women often did not differentiate between hospital-based midwives and obstetricians. During experiences women viewed as negative, they were seen as a collective ‘they’ who were responsible for imposing aspects of medicalised birth.

agreement between women and SECMs, were not mirrored in the experiences described by obstetricians and some HMWs. ⁽ⁿ⁼⁹⁾

Clair, (HMW):

We were going to do an FBS, but we couldn't, they wouldn't give us consent for that and we were now looking at a trace that we felt really bad, there was fetal distress, the baby needed to be delivered. We were looking at a caesarean section. And we had to call in one of the consultants, because they weren't giving us consent for either a FBS or a caesarean section ... it was really difficult, she [the woman], was talking about her plans for a normal birth and skin-to-skin and we were saying we have to deliver your baby, no, best case scenario the baby will go to the unit [NICU]. It felt for a very long time because we were waiting and just looking at the trace, I just remember at the time thinking 'Oh My God, this isn't going to go well'.

Hospital-based staff felt that the label of 'bad cop' was not warranted. Many of the HMWs ⁽ⁿ⁼⁹⁾ described as traumatic their experiences of trying to support women who "did not want our help" (Myrna, HMW) and who in their view did not realise the "seriousness of the situation" (Dervla, HMW).

Tegan, (HMW):

Occasionally they are quite angry that they had to transfer in, and quite hostile towards the hospital staff, and a lot of times they can be quite resistant towards the interventions that are required to delivered their baby safely ... so they may need oxytocin, they may need an instrumental delivery, they may need an episiotomy – and they're very angry too about that.

The obstetricians were more critical in their comments and frustrated when women refused care: "Why come in for our help if they are not going to do what we advise?" (Sheena, Obs).

8.9.2 'What do they expect?'

The obstetricians questioned some of the women's expectations and the information that underpinned their opinions.

Brenda, (Obs):

I don't know what these women are told ... but you wonder how realistic it is?

Sheena, (Obs):

I'm not sure how well the independent midwives prepare their patients for the possibility of transfer and I think part of that dissatisfaction comes about because they haven't and because the patients have a utopian view of what is going to happen.

They were very critical of “*the women's lack of preparation*” (Triona, Obs) for all aspects and possibilities in relation to labour and birth. They suggested that women did not have realistic expectations and that this affected how open they were to interventions after transfer to hospital. The HMWs demonstrated some understanding of the focus on normal birth pervading the care these women received. The obstetricians were less tolerant, branding it as care that “*set the women up for disappointment*” (Eileen, Obs).

Mafra, (HMW):

They don't want interventions, they don't want to go to a hospital and all that goes with that, they choose home birth and that is the way they thought it would all be. So when it works out differently and they need us to manage the care it's like they don't know what to do because this is all stuff that they didn't think was relevant for them and they didn't want ... that makes it hard for everyone

Saoirse, (HMW):

Some of them have bad impressions of what we do so suggesting anything that wasn't in the plan they made with their midwife is going to cause drama, and often these women just say no because they don't see that things now have changed and that they need to change their plans too.

During my fieldwork I did not observe dramatic struggles in relation to care; however, in interviews, both women and healthcare professionals mentioned such experiences. The dichotomy of home and hospital birth was laid bare in these interactions, with each questioning the intentions of the

other, remaining dubious of the merit of a contrasting thesis and the rationale underpinning it.¹³³

8.9.3 'A group you will never please'

The hospital-based healthcare practitioners in this study were aware that, at times, women were not satisfied with their experiences of hospital birth. Several reasons for this were suggested, which have been identified both in this and the previous chapter. In their descriptions of the more "difficult" (Clair, HMW) encounters at transfer, HMWs⁽ⁿ⁼⁶⁾ and the obstetricians suggested that "no matter what happens these are a group of women you may never please" (Eileen, Obs).

Sheena, (Obs):

Birth is a dynamic process, things can change, you may need to rupture my membranes, you may not, you may need to give me oxytocin, you may not, you may need to do an episiotomy, you may not – but the women who say "I definitely don't want this, I definitely do want that, I definitely..." are the group, I think, who often are very disappointed in their outcome because they have this view – who it's engendered by I don't know, that you should have a birth plan, you should try and stick to it, this is the way it should go,¹³⁴ and then often get disappointed. So that group of women who wanted to deliver at home with an independent midwife invariably are often a group of women who are probably anti-hospital to an extent anyway, and then they've built up a trust and a relationship with a woman over the course of their pregnancy, now they find they've to come in to hospital and things have changed and now we need to enact the care we deem appropriate. And even if their outcome is fine, as in healthy baby, healthy mother, good outcome from our point of view, they are dissatisfied because things have not turned out the way they wanted it to do. So I personally think that there are a group of people we will never satisfy. I think there are people who are just very distrustful of hospitals, of obstetricians no matter what we do.

Unrealised expectations of birth were held responsible for women's negative experiences. The obstetricians in this study deemed that any

¹³³ Although data that emerged from the interviews with the obstetricians generated a very negative picture of in-labour transfer and the interface of home and hospital birth, other participant groups recalled some positive experiences of transfer and of birth in hospital.

¹³⁴ Obstetricians also have a similar template of 'shoulds' relating to the medical management of birth.

deviation from “*the*” birth plan (Triona, Obs) placed hospitals and hospital care in a poor light. Some HMWs believed that they were sympathetic to this predicament; this was evident also in some of the narratives recalled by women (Section 8.10.1). The obstetricians were more matter-of-fact in their reactions, suggesting that in these scenarios there was little they could do but “*persuade women that they need what we are suggesting*” (Eileen, Obs) so that they could provide care as they saw fit.

Obstetricians, like all the other healthcare practitioners in this study, spoke of ‘woman-centred care’ and of ‘women’s choice’; however, their interviews demonstrated that they did not always believe that women made the ‘correct’ choice. These narratives evinced a perception among the obstetricians of a dichotomy between desire and safety. An extract from Brenda’s interview provides the most firmly held opinion of all the participants that on occasions *what women want versus what women need* was the foundation of all the conflicts at the interface between home and hospital birth and women’s unhappiness with hospital birth.

Brenda, (Obs):

If you are one of three in a thousand you are [...] by definition, one of a minority, you’re one of a determined minority and it does not necessarily mean to say that your choices may be based on your determination to achieve what you want rather than on what is suitable for you. So it’s not infrequent that people wish to pursue this when maybe it would be seen as in their best interests to go with the flow and have their baby in hospital. So I suspect there would be a high proportion among that very small minority of people who are extremely determined and do not wish to have their choices interfered with in any way.

In this and points made by the other obstetricians and HMWs ⁽ⁿ⁼⁶⁾ it was apparent that these practitioners held their knowledge of “*what is best*” (Clair, HMW) in high regard, and that the women who questioned the care were challenging the prevailing medical hegemony. Hospital-based practitioners met this challenge in different ways; some negotiated care paths with women, while others (as noted in this section) used the powerful medical discourse of risk to counter any resistance. ^{Fieldnote 18}

8.9.4 ‘You have to plámás¹³⁵ them’

Tegan, (HMW):

We kind of plámás them a little bit and get the women on our side a bit more ... sometimes it's the only way, you know, go gently in the hope that they will just work with you so we just get the baby out safely.

Negotiating women's resistance to hospital care was a feature of the experiences of hospital-based midwives and obstetricians. Section 8.9 noted that, in some scenarios, understandings of birth clashed during disagreements about the interventions required after transfer to hospital. Midwives and doctors viewed these as frustrating experiences given that they believed their care to be “*the safest route to take*” (Ita, HMW).¹³⁶ In many cases, they indicated that they considered it the *only one* to take.¹³⁷

When discussing how to “*deal with*” (Brenda, Obs) these conflicts, hospital-based practitioners talked about birth in terms of the obstetric understanding of safety and risk, and using this discourse as a means of ‘persuading’ women to their way of thinking. Obstetricians focused on their perception that all actions and interventions were to maintain the safety of women and their babies. Some of these interactions demonstrated a certain acknowledgment, even in their act of driving care, of the beliefs women held:

¹³⁵ *Plámás* is an Irish word that has become a part of Hiberno-English. In this context it means to cajole (Diarmaid Ó Muirthe (2006), *Words We Use: The Meaning of Words and Where They Come From*).

¹³⁶ As recorded in Section 8.9, women and SECMs questioned the absence of choice in some of these experiences.

¹³⁷ My diary entries reveal that I struggle with my reflections in relation to this data. I am the hospital midwife willing the woman to work with me in light of a clinical situation I believe warrants obstetric intervention. I am also the woman who wants my voice to be heard, looking for assurances that the care suggested is necessary, in keeping with the best available evidence, and is not just the routine of obstetrics. I think back to Arlene in Section 8.10.3 frantically looking for a sign that the strangers she encountered in hospital had her best interests at heart, and I think also on Aoibh's experience; it strayed far from her birth plan but she viewed all the interventions as vital and necessary, and she felt included in the decision-making throughout her birth story.

Eileen,(Obs):

I mean you've almost got to talk somebody down. It's like they've pushed themselves into a corner, and you've got to coax them out of the corner, and convince them that the action that you are proposing to take is not that bad, and you're doing this to try and expedite delivery to maintain safety, you get them round to seeing this.

In other examples there was a sense of impatience and little tolerance of contrasting viewpoints.

Brenda, (Obs):

I suppose we would try to deal with it like we would any other patient, but if there is any reluctance to be there it's difficult to have the same amount of empathy with that person than if they do want to be there.

The more urgent a situation was considered to be by hospital-based practitioners, the more explicit the language of risk and danger they used:

Clair, (HMW):

... we got the consultant in, I went in and we had to really start talking about 'we have to deliver your baby or your baby could die', you know, best-case scenario the unit [reference to the special care baby unit], things like that ... but it seemed to take so long and I was just watching the trace and it was getting worse ... all I kept thinking was 'hurry up and consent, what are ye waiting for?'

The experiences of HMWs and obstetricians indicate, that, from their perspective, on occasions, the time spent coaxing women was not appropriate given the clinical situation and, at times, the need to expedite elements of care.

Dervla, (HMW):

... it can take a long time, they question everything and look for lengthy explanations and that's fine at home when everything is going well, sometimes, depending on the urgency of what is happening, there isn't time for that here.

HMWs suggested that the continued presence of the SECM is one way to bridge the divide between women's expectations and the need to introduce

unplanned interventions into the woman's care (Section 8.8) Obstetricians made reference to the need for preparation for labour and birth to be grounded in "a more realistic" (Triona, Obs) discourse that prepared women for all eventualities that birth could take.

HMWs and obstetricians were critical of the amount of time spent discussing things with women, and convincing them of the care they needed. However, when looking back and reflecting on their experiences of birth, many of the women⁽ⁿ⁼¹⁴⁾ raised questions about their lack of involvement, at any level, in the decision-making once they transferred to hospital.

8.10 Birth in a Different Space

The narratives around birth in hospital exposed the complexities and contradictions that this held for women in this study. The negative perceptions of maternity hospitals as understood by some of the women were in keeping with the reality of their experiences; e.g. "*it went from bad to worse, as I feared it would*" (Geraldine). Others recalled experiences that surprised them; e.g. "*it wasn't as bad as I thought it was going to be*" (Jenniver), "*they were much nicer than I had expected*" (Cara). These constructions were influenced by the reason for transfer and the nature of their interactions with hospital staff. For the most part, women judged these interactions in terms of the manner in which they felt their wishes had been acknowledged and respected, even if they did not realise their plans for birth. The ethnographic descriptions of hospital birth offered by women contrasted, mainly, with the narratives displayed in Section 8.2. They highlighted how discourses of safety and risk, power and trust influence the experiences of in-labour transfer and women's perceptions of their birth story.¹³⁸

¹³⁸ Throughout this thesis, it is difficult to quantify the experiences of birth. My best attempt found that five women had extremely positive experience of in-labour transfer and birth in hospital, five determined that their experiences were 'awful', 'traumatic' or 'terrible'. The other 15 situated their experience somewhere in the middle, with positive and not-so-positive features in their stories and the sense they made of their experiences.

8.10.1 'I was lucky, I met a good midwife'

When telling their stories of in-labour transfer and birth in hospital, women predominantly referred to HMWs, with little comment about doctors (the notable exception were the women who described their experience as *terrible*). I found this puzzling, given that in my knowledge of the maternity services in Ireland, I was aware that at the very least a junior doctor would have been involved when the woman was admitted to hospital. I recontacted five women¹³⁹ to ask about this. These women were not sure if they had met a doctor; one woman told me "*they were all in those scrub clothes; I really didn't know at the time who was a doctor or who was a midwife*" (Gwen). It is therefore possible that some of the women mistook doctors for midwives. While this section refers to the '*good midwife*', the '*good doctor*' may also apply. This situation throws into sharp relief the differences between the association with an unknown person (not knowing if they were doctors or midwives) and the pre-established relationship between women and their SECMs.

Several references have been made in this chapter and Chapter 7 to SECMs' and women's concerns about the HMW they would encounter on transfer to hospital, and SECMs' attempts to go to a hospital where they would know the staff. Their anxieties were grounded in the belief that they would not meet a supportive midwife. Some of the women even perceived that the midwife would "*be really against me*" (Sineád), "*think me reckless*" (Blaitthin), "*have an 'I told you so' attitude*" (Cora). However, nine of the women (including the three quoted) recounted interactions that were not in keeping with these assumptions.

Cara:

... the experience was positive really from the beginning ... I thought it was going to be so awful. I thought that people were going to be rolling their eyes and going 'homebirth, so irresponsible and then they end up here and we've to clean up the mess'. I really thought I was going to get a fairly

¹³⁹ I contacted women who had made reference in their stories to issues that indicated to me that a doctor was present (e.g. syntocinon infusions, discussions about instrumental births, reviews of fetal heart monitoring).

aggressive attitude and I didn't get that at all. They were very professional first of all and then quite warm.

Norah:

The shift changed and [x] was the next midwife and she was just really lovely and yeah, again it was just getting me to the right place to have this baby, and she helped me get there, and I can't even remember exactly how she did it but she was so caring, I was so happy that she was the one there when he was born, not the one before that.

The women were pleasantly surprised by the support they received from these HMWs; this support related not only to their care in hospital but also to their original choice to birth at home.

Jennifer:

I felt kind of welcome in the beginning, it was nice and they were there and they were really sympathetic in a sense of just expressing that ... they were really sorry that I had to come in, that I wasn't going to have a home birth.

Given their antenatal experiences, women assumed that the interactions at transfer would be confrontational and that they would again need to justify their decision to have a home birth and be met with a 'told you so' attitude.

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HMWs who acknowledged that transfer and birth in hospital were far from these women's expectations were praised. Recognising that the women had lost something (e.g. "... *letting go of my dream*", Norah) was considered important. These HMWs showed an understanding of the women's expectations for birth and "*did not make me feel like I had to give up all of them just because I was in hospital*" (Maireád).

Aoife:

I just remember the midwife coming out to the door to meet me, taking me by the hand and saying "Ok, let's figure out what's

¹⁴⁰ In the current organisation of maternity hospitals in Ireland, many of the midwives do not rotate from one clinical area to another. So e.g. a midwife may practice on a postnatal ward for a long number of years. It is worth noting that the women during their antenatal encounters may have met HMWs with limited or historical exposure to labour perhaps explaining their fear of home birth.

been going on and where you want to go next” and that is what I wanted to do – figure out what was needed to get back on track.

A thread to emerge in the narratives of these nine women was the value they placed on having a normal birth (or a birth that required “very little” intervention). It was perceived that the support of the specific HMW and the manner in which she “kept interventions to a minimal” (Armelle) was instrumental in facilitating normality in hospital. It is impossible to say which factor begot the other;¹⁴¹ nevertheless the women believed that the HMW was responsible for making minimal intervention possible.

Clodagh:

I had a birthing plan with Cliodhna [SECM] and we had worked on it for seven months, what we wanted, our experience, what she wanted us to experience out of it ... and it was really strange because the midwife went with our exact birthing plan. I don't know if she read it but she had our file in anyway because Cliodhna had handed it to her ... and although she didn't really do anything like, well she did, she was there, but she just let me do it on me own and it was so much easier than someone panicking around, there was no 'push' shouted like the last time in hospital. She just stood there and just let me do it and it was great. She was brilliant, so calm the whole way, she kept saying to me “Come on, you're doing this on your own, you're doing it on your own, it's brilliant”, she was encouraging, it wasn't a big deal, it was just having a baby, it felt the way it was supposed to feel, I didn't experience that with the others [births] and when we had to transfer I didn't think I'd have it this time either ...

In other parts of Clodagh's story she focuses on the “fun” she had with the HMW and how in this different environment she felt facilitated to fulfil elements of the birth she had planned for home. HMWs, too, recounted scenarios where they felt that they were able to facilitate choice and they received positive feedback from the women. Interestingly, in their interviews, the midwives did not give as much attention to such cases as they did to experiences involving conflict: “*She came in and it was grand, we got on with it, got the epidural and she was fine, lovely, delivery all worked out great and she was happy*” (Ita, HMW). As is evident in the

¹⁴¹ That is, the labour did not require intervention, or the lack of intervention supported a more normal experience.

midwives' narratives (e.g. Section 8.6), these positive experiences are not always the ones remembered in hospital lore.

The interactions during these experiences were helpful from the onset; women felt supported and their plans for birth were considered and respected by the hospital-based staff. The women in no way suggested that their experiences mirrored their overall expectations of birth, but any negotiation was deemed more acceptable in the context of acknowledgement of their previous plans and understandings of birth. Section 8.7.3 drew on the midwives' perceptions of a seamless interface between home and hospital birth that meets women's needs; the encounters explored in this section demonstrate women's experiences of such integration.

8.10.2 'Against all odds I still did it my way'

Other women⁽ⁿ⁼¹¹⁾ did not report supportive interactions with HMWs. They recounted attempts to resist the routines of care that underpin the culture of hospital birth in Ireland. The resistance was not just to the interventions embedded in the medicalisation of birth,¹⁴² but also to other routines of surveillance and hospital care, such as restricted mobilising during labour (Jenniver), no baths allowed (Gilda), no food allowed (Norah), confinement to bed for birth (Cora), directed pushing (Aideen), limits on the number of support people allowed (Maireád), the open-door, all-enter policy of the labour ward (Blaithin).¹⁴³ These women spoke of "disagreements" with HMWs and their struggles to have any sense of control over their experience.

Jenniver:

I just remember that they wanted me to go on the bed and I couldn't. I had to be very firm on that, I would not lie down for anything ... they were not happy and there was a bit of toing and froing but in the end they got over it ... lying down was not

¹⁴² Syntocinon infusion for augmentation of labour was the most commonly quoted example.

¹⁴³ Women spoke of the distress they felt with people just "wandering in and out [of the room], no knocking, no excuse me, just a 'can I have the keys'? or 'is doctor x in here'? to the midwife with me ..." (Gilda).

in any way necessary, what would that have helped? So I kept moving for as long as I could ...

Women suggested that, at times, the midwives were surprised by any form of resistance to the care they provided. HMWs often defended the instructions they issued with comments such as “*oh no, this is what we do here*”, “*that’s the hospital policy*”, “*one midwife told me – ‘you’re not at home now dear*” (Carys). I must admit my amazement as this emerged from the data. I assumed that there would be disagreements about the medical management of birth;¹⁴⁴ I had not anticipated that women would encounter such firmly entrenched local customs and practice.¹⁴⁵

Gwen:

... they had me on the bed with the machine strapped onto me and then she wanted to put on an internal monitor, I just looked at her, I said no. They said “It’ll be good and make it easier, we do it when women have an epidural”. I asked, “Easier how?” I’m still not sure ... and I refuse to let them do it ... they were still able to record the baby’s heart.

Maireád:

... that was it, there was no way anyone else was coming into the room. My mother was sent packing. I was nearly made to feel lucky that they were allowing my husband to stay. “I person policy” – that is all they kept telling me ... it made no sense, we were going into this huge room like an operating theatre, it’s not like they would have been getting in anyone’s way, and I needed them ...

Some of the women were successful in their challenges. Others did not achieve their objective, finding it difficult to move midwives from their “*that’s just the way we do it here*” mantra (as told to Bríd). Four of these women said that eventually they ‘gave up’ fighting, Arlene said that “*at this stage they had just worn me down; I just hadn’t the energy to do anything*

¹⁴⁴ Hospital-based midwives mentioned the challenges they faced when women did not agree with care as per the hospital’s guidelines. Their concerns related to oxytocic infusions, IV antibiotics, time frames associated with active management. Discussion about ‘positions during birth’ did not emerge in their narratives.

¹⁴⁵ My diary entry in relation to this point makes reference to 1999 and my first post as a midwife in a hospital in Ireland. A very senior midwife brought me into a room on the labour ward to show me how to “*deliver the [x hospital] way*” as the woman was told what position on the bed she was to assume during birth. This shocked me in 1999; when these findings emerged over a decade later, I was disappointed.

else about it, I couldn't even make sense of it, they weren't listening, just doing their own thing". ^{Fieldnote 19}

Armelle:

So I had to stay in there, this is what I didn't want, with a monitor around me, labouring lying down, and I was "are you kidding me ... I can't do this". I was having whoppers [contractions]. I said "I have to sit up". So I sat up and ...after an hour and half I said "Can I take this off now?" ... she goes "No, that has to be in the whole time you're here" ... I asked her why, was there something wrong? And she said "No it's fine, but it just has to stay on" ... so there I was lying there, so uncomfortable ... but it is 'unit policy' and she wasn't moving from it ... and at the time I just felt that there was nothing I could do about it.

When contrasted with care at home, these experiences were viewed unfavourably. Prior to transfer, women had choice and control in their own space; negotiations occurred within a relationship of trust between people with a shared understanding of birth. Establishing their choice was not easy in the hospital where it was considered the space of midwives, obstetricians and "*their protocols*" (a term used by Geraldine). Women found it difficult, in the context of their most recent experiences at home, to work out a way to find their path in this space.

Jenniver, (fieldnotes):

The more Jenniver reflected on her experience, the more her frustration seemed to grow. She seemed to have a need to justify her actions (or inactions); after the interview she said, "I could handle it now, deal with it better ... but in the middle of labour, and you've just given up your home birth ... and you're totally distracted with the labour ... it's just too much going on ..."

Those⁽ⁿ⁼⁷⁾ who felt that they maintained some control over their experience, in spite of the unsupportive interactions, suggested that this was not easily gained. "*You had to fight for it*" (Norah), "*you had to be determined*" (Aoibh).

Norah:

When I went in, with that first midwife... I knew that she wasn't happy with me, I could tell from her looks, the tone of her voice ... you could cut the atmosphere. I was so glad when her shift was over.

Against this background, interactions and experiences were described as “*stressful, unpleasant, certainly the last thing that I needed in the height of labour*” (Gwen). The trust that was so apparent in the relationships at home was not evident in these women’s experiences. They did not believe that hospital-based staff would deviate from the routines of care and intervention embedded in the hospital culture, regardless of women’s wishes.¹⁴⁶

Cora:

It was exhausting, being on high alert the whole time watching everything they did and [said], and having to challenge every suggestion, that wasn't really a suggestion, it was more of an instruction.

In making sense of their struggles to maintain control of their care, these women⁽ⁿ⁼⁵⁾ suggested that “*against all odds I still did it my way*” (Gwen). These women felt that they had, in the face of opposition, resisted aspects of care that were not in keeping with their understanding of birth; for example, “*I avoided a c-section*” (Aoibh), “*I did not have syntocinon*” (Jenniver), “*I bought myself some time*” (Rona).

Blaithin:

I was so proud of myself, I had a natural birth without unnecessary interventions ... when it got to the point when they were stressing interventions, the drip and stuff, that freaked me out ... but I held firm and I only took what was completely necessary. I was very happy with the birth, I had a natural birth.

¹⁴⁶ My diary entries underline my reading of some of these experiences and the way I reacted to some of the interventions women spoke of. At times, I considered these necessary elements of care rather than routine. Reflections on this drew my attention to a number of things: (1) whether I was thinking like a ‘hospital midwife’; (2) that I needed to remain focused on the context and background in which these experiences occurred, and (3) how these experiences differed from those recalled in Section 8.10.1 even though the level of intervention, etc may have been similar.

Cora recalled at several points in her interview, "*I did it myself ... I still managed to do it*". Birthing 'normally / naturally' was held aloft as proof that birth plans had been realised and that women had power over their experiences.

Cora:

I was like 'no, you're not clipping anything to me, you're not strapping me to the bed, you're not doing anything to me, you do not need to do anything, I am fine'. I just wanted my waters broken. It was a battle, everything was a battle, people in and out to me, but I was firm.

All the time I was thinking 'oh, they just do this all the time, they just do this and they do that', and they do it by routine and what if I want it slightly differently and if they don't do it the way I want it ... so that part I suppose was stressful.

... but I did it, I did it myself and my way, in spite of all that was going on and the fact that I was so exhausted, so fed up, I still managed to do it ... I had my normal birth myself.

I asked three of the women about this. I read this '*I had my normal birth*' as akin to considering '*mode of delivery*' as a sole indicator of satisfaction with labour.¹⁴⁷ They stated that focusing on something positive helped them to make sense of their experience. One woman said, "*I had to hold onto something, otherwise all that effort, what was it all for*"? (Jenniver).

Even in these narratives of '*I did it my way*', I read compromises in women's encounters and moments when the hospital-based practitioners dismissed or tolerated their needs, thus directing the decisions made. In Cora's telling of her birth story she focused on her power within her experience; however, in her account I read examples of hospital custom overriding her needs and her wishes.

Cora:

I wanted to squat on the floor and they wouldn't let me, "Oh no, you can't have the baby on the floor, you have to get up ...

¹⁴⁷ I have over the years heard several hospital-based practitioners ask: '*She had a normal delivery so what's wrong with her?*' when women said that their experiences were not positive.

kneel on the bed if you want to do that sort of thing". I was going 'No, I don't know if I can', and they were like – "No, you have to be on the bed, just turn around backward and get up". So I had to ... and there I was, lying on the bed, in the one place I didn't want to be to give birth.

Rona said numerous times “*I was in control of my situation*”, yet I perceived, in my reading of her story, that her ‘control’ was in fact subject to the discretion of the doctor on call.

Rona:

So I said to [doctor x] how long will you give me and [x] said “I’ll let you do it, if you’ve the urge to push just go with it and I’ll let you do it”. And I started pushing and I remember [doctor x] used to keep kind of looking in the door and I used to keep saying to go out and I could see him and I used to say “I’m fine” and I kept watching the clock I remember to see how long was this taking me because I knew he was watching the clock too and I was adamant I was going to do this and I did it. I think I was about forty minutes pushing, yeah, and I delivered her on my own.

Even in the moments when women considered that they were in control, there are indications that the hospital-based practitioners held the authority to veto women’s choices and insist on care on their terms.

In navigating the routines of hospital and the interventions considered ‘normal’ therein, these women made reference to their SECMs and the role they felt that they had in guiding them through the customs and the practices of hospital birth, as they had guided them through birth at home.

8.10.3 ‘Who will I trust?’

Section 8.8 explored the healthcare practitioners’ experiences when the SECMs remained with the women after transfer to hospital. Mixed opinions emerged from the HMWs and doctors; however, the women cherished the continued presence of their SECM. The continuity of care offered by these specific midwives was identified as one of the reasons for planning a home birth (Section 7.2.1.1). The relationships with the SECMs, and the trust therein, were central to women’s experiences of care (Section 7.7). In the presence of their SECM, women said that they felt “*safe*” (Cara), and they

wanted that to continue during their experiences in hospital. Nineteen women who experienced an in-labour transfer wanted the midwife they knew and trusted to remain with them throughout. Two main reasons for this were offered and can be summarised using the words of two of the women: (1) “*No one else knew me as well as she did*” (Eibhlin) and (2) “*I trust her, I knew she would see me right*” (Ailis). For these women, this relationship was held as *the* support they needed and it outshone any other interaction during transfer to hospital. Diary Entry 20

Carys:

I knew at that stage I would need some intervention but that she would protect me from the unnecessary ones.

Rona:

I felt once Bridget was there nothing was going to be done that I didn't want done. I kept thinking if she is with me then everything will be ok, because she'll be for me and she'll mind me if I'm not able to mind myself.

Akin to the hospital-based practitioners' suspicions of SECMs, women were suspicious of hospital midwives and doctors. As noted in Section 8.10.2, women did not trust that their choices would outweigh the routines associated with birth in hospital. The SECM was regarded as the “*protector*” (Ailis), “*making sure that no one did anything that they didn't really need to do*” (Cara).

Eibhlin:

So I just looked at her [SECM] the entire time and she was really great and I just looked into her eyes, which was really helpful, she was so with me the entire time and made me feel like everything was okay and she was looking out for me.... she [SECM] didn't have to say anything, it's the fact that she knew exactly how to be with me.

The stories recalled by these women demonstrated that the SECMs knew the women, and spent months learning and working through their expectations of birth. They knew how to be with them during labour, what had happened prior to transfer. Women trusted them, trusted their practice and trusted that they would keep them safe in the environment of hospital

birth, the space women perceived as the territory of midwives and obstetricians. Women trusted that in their moments of pain, tiredness and feeling vulnerable that their SECM was “*there for me*” (Lana).

The SECMs spoke of feeling caught between the women and the hospital midwives. The women, in the throes of labour, did not see their conflict; they saw the SECMs as the bridge between themselves and hospital-based practitioners.

Gilda:

... and I remember at one point they [hospital-based practitioners] said something and I was like “what?” I mean at this stage we were so shattered we really had no clue what they were talking about and the SECM translated it into language we could actually understand. It was really a relief, to have the SECM there. It was just that, that bridge of care, you know between the hospital and us and also the consistency of her.

Repeatedly, women spoke of their need to discuss things with their SECM, to help them decipher the new pathway of care, to assist them in identifying the aspects of care (intervention) they considered necessary and those that were embedded in the culture of routine. This emerged from women’s experiences with their SECMs beside them⁽ⁿ⁼⁷⁾ and scenarios when the SECMs had to leave⁽ⁿ⁼¹²⁾.

Three of the women went to lengths to maintain the support of their SECM after she left. Jenniver’s husband went to the bathroom and texted their SECM whenever there was something she wanted her to clarify. Similarly, both Blaithin and Norah were aware that their SECM was still in the hospital and both women “*sent*” their partners to liaise with them.

Norah:

Caoimhe told me she’d hang around for a while, so I sent Cian [partner] looking for her whenever I needed a question answered. I wanted her answers because I trusted her so much to explain to me if there was anything wrong with what they were suggesting. You know, it would have been an awful lot more relaxing if I could have had Caoimhe there, making

decisions with me rather than sending someone out looking for her.

All the women in this study were supported by their partner or husband. Most⁽⁼¹⁶⁾ women were told on transfer that they could have one person with them in the labour ward. At the time of interview six of the women wondered if they should have asked their SECM rather than their partner to stay, such was the value they placed on their relationship.¹⁴⁸

Women⁽ⁿ⁼⁵⁾ who recalled extremely negative experiences in hospital talked of their unsuccessful attempts to somehow replicate elements of their experiences with SECMs in their interactions with hospital midwives and doctors. These narratives demonstrated an absence of the choice and trust that were deemed so vital in the relationships with SECMs.

8.10.4 'It was all I didn't want it to be'

Arlene:

... the midwife said to me "What time did your waters break?" And I said – "Well, I don't know if my waters broke to be honest" ... and she said again "WHAT time did your waters break?" And I said "10.30, if they have gone because ..." and she just cut across my explanation and straightaway I knew, I just knew where this was going to go with her. Her attitude was 'Hurry up and get to the point, don't be telling me your stupid story, WHAT TIME DID YOUR WATERS BREAK? I'm a busy woman, tick-tock'. I just went 'oh no ... this is going to be exactly what I don't want it to be. This is going to be that story that I've heard before'.

As I documented at the start of Section 8.10, five women¹⁴⁹ described all elements of their experiences in hospital as 'awful', 'traumatic', 'terrible'. In these cases, the women felt that none of the hospital practitioners acknowledged their wishes to birth at home or made any reference to maintaining aspects of their plans within the care offered in hospital. The women labelled this as disappointing care that placed little value on birth outside of "*the customs of the hospital*" (Brid). These women suggested that

¹⁴⁸ One woman chose to have her SECM rather than her husband present; this choice was challenged by the HMW and 'not allowed'.

¹⁴⁹ In four of these experiences the SECM was not present.

the doctors' and midwives' opinions of home birth were made obvious very early into their interactions. Geraldine and Carys observed interactions they interpreted as midwives and obstetricians having little regard for the SECM and for home birth.

Geraldine:

... we arrived in and the bloody same obstetrician¹⁵⁰ was on duty and she walked in and she goes "So, we meet again". And it just went from bad to worse ... absolutely bad to worse.

She [obstetrician] completely discounted everything and ignored everything the SECM said, she wrote down on the notes [I requested the notes afterwards], she wrote down "presented at whatever..." and she had "transferred from home" but she hadn't written down that I had been labouring at home or anything that Peig had said. She [doctor] refused to interact with her [SECM], refused to talk to her and wasn't interested in listening to anything she had to say. So I just felt she'd hardly be interested to hear my version of events either or what I wanted ... and she wasn't.

Women perceived that the hospital-based practitioner's readings of home birth also influenced the way they interacted with them. The exchanges recalled by these women indicated confrontation from the onset and contrasted dramatically with their interactions with their SECMs (and indeed with the experiences shared by women in Section 8.10.1). These women felt that *"they were working against me from the minute I arrived in the door"* (Carys). They experienced the barriers described in Section 8.10.2 but their attempts to resist the routines of care were futile. The women suggested that, while their aim was to maintain some control over their experiences, the hospital-based staff gave them the impression that they thought they were *"causing too much fuss"* (Brid), *"taking up too much time"* (Arlene), *"telling them how to do their job"* (Geraldine); *"I think they just thought I was being awkward"* (Carys), *"I was silly"* (Arlene).

Arlene:

I asked about skin-to-skin, "We do that anyway as standard", almost 'stop being silly', I felt like I was silly, I was a silly woman coming in with her fantasies and I needed to just let

¹⁵⁰ Geraldine had a negative interaction with this obstetrician during her pregnancy.

them do what they were doing and get on with it. I was a silly woman asking for silly things, taking up too much of their time

In Section 8.2 I painted a picture of my observations of home birth and my perception that women were at the centre and the focus of care. I described the *bespoke midwifery care*, the midwifery care that was so personal. In the Sections of 8.3 I provided an insight into the decision to and preparation for transfer to hospital. Even in these times of disappointment or urgency, agreement was negotiated through the well-established relationship between the women and the SECMs. The stories shared by these women about their hospital-based experiences did not reflect personal care, nor did they present episodes of negotiation. These women felt that their experiences were engulfed in routine: “*No one cared about me, the person*” (Brid).

Brid:

... they're looking after themselves because it's their job; they're not looking after you. They're just doing it by rote, you know.

Arlene:

I was nice to her [HMW], I was really nice and I wanted her to be really nice back to me ... we went into the room, “Hop up on the bed”. She put that thing on me, all the things I didn't want, I never wanted to be tied down to a bed And she was asking me questions I can't remember about what, but she never put her hand on me and said ‘I know this isn't what you wanted but we'll do our best to ... to make you feel at home’ ... or anything ... I don't know what I expected but not this, it was so cold. I kept using her name after every sentence in the hope that she would use my name back ... just something to feel like there was a connection with this person ... nothing she gave me, nothing.

This contrasted greatly with their experiences of care during pregnancy and up to that point in labour. In these situations these women felt that their needs, as they saw them, were being completely ignored. They suggested that the hospital-based staff “*could have asked me*” (Brid), “*could have considered my opinion*” (Aideen), “*they could have at least pretended that they were interested in what I wanted*” (Arlene), but instead these women

felt that hospital routine prevailed and “*I was left having to just do what I was told*” (Carys).

The feeling that their opinions were of no consequence left these women describing birth experiences that were in keeping with the worst expectations and fears as described in Section 7.2.1.2 and fulfilled their expectation that one person in the hospital had the potential to influence the route their experience would take.

Geraldine:

... we had agreed, if I was transferring I was transferring for a c-section. We agreed antenatally and with the consultant, if I couldn't get the baby out at home and that stage I wouldn't do it in hospital and I would have the operation. And then we had to meet the one person who [the doctor] wouldn't listen to what we had to say ... what a stressful, awful encounter to have in the middle of a labour that was going wrong...

Arlene:

... it was so bad from the start, every little thing ... it was a terrible, terrible experience. Ok I wasn't going to have my home birth but it didn't have to be terrible ... and that was her fault [HMW], I blame her, it was her attitude ... I got nothing off her, I didn't have to feel so scared, you know she didn't have to make me feel like I had done something wrong...

Women searched for moments of trust in these interactions. Interventions such as augmentation of labour, instrumental birth and caesarean section were mooted by hospital staff, interventions that women said they had wanted to avoid. These women needed a sign that these proposed interventions came from a place of genuine concern as opposed to following the customary practice of hospital birth. Their experiences here, again, contrasted with all the narratives of trust in the relationship between women and SECMs explored in this and the previous chapter.

Arlene:

I didn't trust them then at that stage, I just was begging them for reassurance, and I didn't believe them ... there was no trust, and then there was no big gesture of trust. No one said 'I promise you now I'm not going to let anybody come in here

and do that, I'm going to make sure that you know exactly what's going on at all times. Just, it's fine, relax, don't worry'. I was worried, and I wanted to shout 'do something to help me trust you ... give me some sign that you have my interests at heart'... but nothing...

Carys:

I remember they were opening up, you know, a packet of something and I said "What's that?" They said "Oh it's scissors, just in case you need them", and I didn't believe them, I said "No, only if I need them" and the midwife, I could see her roll her eyes and sigh and she went – "We're hardly going to do it if you don't need it ..."... but I just didn't know any more what to believe.

Four of the women did not know if they could trust the need for interventions as suggested by the hospital staff. One woman stated that she did not trust that the obstetrician would provide the intervention both she and the SECM deemed necessary.

Geraldine:

I had no faith in her [the obstetrician], I didn't trust that she would do what I needed because I had asked for it. That sounds awful I know, but I just had no confidence in her so I got my husband to call a friend of ours [a more senior obstetrician] because I knew he'd tell her what had to be done.

Such lack of the kind of trust that was believed to be so valuable in the relationship between SECMs and women influenced these women's opinions of birth in hospital and confirmed any suspicions they held of hospital midwives and obstetricians. These interactions affected the sense they made of their birth stories.

Geraldine:

It was a dreadful, dreadful experience. Having to fight with someone at that intense stage of labour, not being listened to, your wishes ignored, the SECM's opinion disregarded ... I mean who told that doctor that it was her opinion above all things?

Brid:

I was traumatised ... it wasn't so much the procedures, although they were bad, it was the feeling that I had no say in what was being done to me

Carys:

I never, ever got an epidural or any pethidine or anything and at that stage I was begging for it ... The contractions were coming every two minutes and because of all that back pain it just felt like they were constant and the midwife said to me "Carys, all the women are going through this, none are making as much noise as you. Every woman has to deal with contractions coming every two minutes, every other woman in here is doing it and you're gonna have to too." And I just, I know if my SECM could have stayed those things wouldn't have been said and those are the things that stay with you, you just end up feeling useless.

Carys was one of the four women over the course of this study who had a pregnancy and home birth after her experience of in-labour transfer. She contacted me to tell me of her very different birth story at home:

... and so after he was born I could believe in myself again, there were no battles, we were all working together, it was how I had envisaged. He is my healing baby, his birth took away the pain and awfulness of [x's] birth. Diary Entry 21

Not all the women for whom interventions formed part of their birth story had such negative experiences. Three women (Lana, Aoibh and Ailsa) also underwent midwifery and obstetric care that strayed far from their anticipated plans for birth. It was both their own view and that of the SECMs and hospital-based staff that facilitating normality was not possible in their case. Nonetheless, in their interactions at transfer these women held that they were supported and their views respected. The interface of home and hospital was positive even when the rest of their birth story was far from what they had hoped.

Aoibh:

... it was a disaster, but what could anyone do about it? No, of course I didn't plan for x, y, z but that's what had to happen, there was nothing else for it ... no one could change that ... so yes, I was devastated that my plans didn't work out but not

devastated about the care in home or in hospital, everyone did all they could.

8.10.5 'It's not my experience, it's the hospital's'

Regardless of the positive or negative constructions of their experiences, all the women raised the point of ownership of birth when it occurs in hospital. Women considered that their birth stories concluded in an environment that was definitely the domain of midwives and obstetricians. These women suggested that their birth experience was made to fit within the routines stipulated by hospital-based practitioners. Even in experiences that were not described as outstandingly negative, women felt that they had to "go with the flow"¹⁵¹ (Ethna, SECM).

Gwen:

I didn't feel like I had a choice, you know, to have the monitors and to have me all connected to those things, I'd an IV drip as well with fluids first and then the oxytocin and that made it as well constricting....they didn't give me a choice whether I wanted these or not, so I felt like ... that I had to just do it.

The women did not suggest that they had not been offered information by the hospital-based practitioners, but rather that it had often been offered in a way that "just told me what I had to do" (Arlene). In keeping with the obstetricians' opinions of their role of influencing women to make the "correct choice" (Brenda, Obs) (Section 8.9.4), the women indicated that information was offered in such a way as to persuade them to accept a particular route of care.

Carys:

They started talking about syntocinon and that I needed it and I wasn't sure, I just wasn't ready for that. They broke my waters, I wanted to walk around, and see if that made a difference to the contractions. But no, they didn't think that was enough and the sister came back in and said that the time was passing, she was very sort of businesslike and she pointed to her watch and told me "Now in here you will have x length of time to get to fully dilated or we will be going for a c-section, so you need to make a decision and we need to get on with delivering your

¹⁵¹ A turn of phrase used by the obstetricians to suggest what some women should do.

baby”... so when it is put to you like that, in the heat of all that is going on and they are looking at the clock, what can you do?

Women recounted many cases of Hobson’s choice in that information was presented to them as an option when really it was a *fait accompli*; obstetricians and HMWs had decided already the *correct* care to instigate. In this space of hospital birth, many of the decisions were made over short spaces of time. For women who had spent months talking about their expectations and plans for birth with their SECMs, this was in complete contrast to their experiences of home birth. As Aideen’s put it:

Aideen:

... and they kept asking me the same question, over and over. I hadn’t even time to work out what I was thinking or what I wanted when they asked me again. I felt very pushed to make a decision, it was all so rushed...

Eibhlin, reflecting on aspects of her care in hospital, referred to these acts of persuasion as a demonstration of “*powerful knowledge that means nothing*”.

I asked her to explain this to me:

Eibhlin:

... powerful in that they get to call the shots, what they say goes ... when I look back now I know that is not me, not how I do things, not how I wanted things. So really that knowledge or that way of thinking about labour does not relate to my way of thinking, it means nothing to me.

It was not just the routines of active management and the medicalisation of birth that women spoke of, they also noted that care was structured around the work ‘shift’, the daily pattern of the institution, rather than designed around women’s individual needs. The organisation of care was not considered personalised or custom-made to fit the woman’s labour and birth, as care at home had been.

Ailis:

In the hospital it’s not your experience, it’s not, it doesn’t belong to you. It belongs to whoever is looking after you. Because that person is going on lunch now – “I’ll be going on

lunch now, so you wait an hour before you push, and I'll come back and you can push then", like that's what was said to me... It's their experience, what suits them... it's not your experience, it's totally taken away.

The diversity of women's perceptions in relation to their experiences of in-labour transfer has been examined in this and the previous chapter of this thesis. Paramount for all women was their desire and need to feel involved in the decision-making process in their attempt to maintain some control over their experiences.

8.11 Summary Part II

The accounts and observations recalled in this chapter tell of the interface between home and hospital birth in Ireland. I have provided ethnographic details that demonstrate how individual difference in background and understandings of birth influence experiences during in-labour transfer.

The findings juxtaposed women's experiences where there was a seamless interface between home and hospital birth with interactions played out against a background of suspicion, where narratives of safety and risk, power and trust were intertwined with and underpinned the encounters. Birth at home was defined as a space where women's choice was a key determinant. This contrasts with women's experiences in hospital, a site of healthcare professional (medical) dominance where women's experiences were seen as being made to fit into the routines of hospital care.

The analysis of the accounts and my observations of healthcare practitioners identified their understanding of birth, their perception of risk and how this influenced their interactions during transfer. The nexus between risk and trust plays out against a background of contested professional boundaries. The findings illuminate the perceptions with regard to who can be trusted to be professionally competent and credible. The data presented demonstrate also the ongoing influence of the expert knowledge system and the attempts made by SECMS to resist the powerful obstetric discourse of risk that underpins the culture of birth in Ireland yet adapting strategies in an attempt to 'fit in' and gain credibility.

These stories have humanised the experiences of in-labour transfer and also illustrate how the politics of birth are exercised through the everyday experiences of the study participants. In the next chapter, in keeping with the traits of VCRM as recommended by Mauthner and Doucet (1998), I will position their experiences in the wider socio-cultural context of the maternity services and birth in Ireland. In Chapter 9, I will employ the theoretical perspective underpinning this study to position the experiences within a discussion of the knowledge generated by these findings.

(For Fieldnotes and Diary Entries please see Appendix 2, Pages 436 – 438)

Chapter 9: Discussion

9.1 Introduction

“It is trivial to raise the point that birth takes place somewhere, be it in the bush, in a hut in the jungle, or in a modern hospital. What is not quite so trivial is to consider that birth, by the mere fact that it is located somewhere, inevitably takes place on somebody’s territory”

(Jordan 1993, p. 67).

Birth in Ireland is situated in a complex network of social, cultural, historical and political discourses. This study has referred to these discourses when appropriate. As referenced throughout this thesis, home birth is a deviation from the culturally held norm of birth in Ireland and is not in keeping with the dominant obstetric discourse, which informs the provision of the maternity services. For the purpose of this study, a critical ethnographic approach was used to explore the interface between home and hospital birth in Ireland as experienced during in-labour transfer to hospital. Little is known about women or healthcare practitioners’ experiences during transfer; however, this study has identified multiple converging factors that affect their expectations and experiences of the event. Contextual factors intertwined with constructions of safety, risk and trust, as well as perceptions of power have been identified in the participants’ experiences. These influence the choices and constraints that affect women’s experiences and their overall satisfaction with their birth story. These themes also permeated the experiences of midwives and obstetricians. Consequently, references to power, safety, risk and trust have been threaded throughout the chapters.

This chapter recalls and discusses the key findings from this study with reference to the relevant empirical and theoretical literature. Sections 9.2 – 9.5 focuses on the findings that are most pertinent to the aims and objectives of this study. Section 9.6 discusses how the theoretical writings of Michel Foucault, Mary Douglas, Ulrich Beck and Anthony Giddens (as summarised in Chapters 4 and 5) provide a mechanism for understanding some of the findings that emerged from this study. In my final discussion, I

will highlight the contribution that this thesis makes to knowledge and its potential to improve the maternity services for all involved.

9.1.1 Revisiting the Findings, with Reference to the Literature

This study was conceived in 2009 and commenced in September 2010. Site preparation began in 2011. During the early stages of the research, scant published qualitative data in relation to the area of interest were available. As shown in Chapter 2, most of the research concerning transfer relates to rates and causes of transfer. In the period between my initial foray into the world of home birth and the final write-up of these chapters, some relevant studies were published, in particular Cheyney et al (2014a) and Fox et al (2014). Both these papers were published after I had completed my data collection, and I decided not to read them until I had concluded data analysis and written up the findings chapters. I wanted to ensure, as best as I could, that the ethnographic story of this study and the findings emerged from the participants, and that I was not influenced by recent studies with a similar focus. When I did read the papers and compared the findings of my research to these studies, some similar themes were evident (outlined below, as appropriate). This indicates that the findings of this study are transferable.¹⁵² It was interesting to find that there is not just a similarity in themes but also in the language used by the healthcare professionals between this study and that of Cheyney et al (2014a), conducted in America. Examples of similar language are: the “*you-never-know-what-you-are-going-to-get*” argument suggested by hospital-based certified nurse-midwives (CNMs) when expecting a woman from home birth (p. 447); CNMs’ opinions about the “*good/bad*” reputation of home-birth midwives (p. 448); community midwives feeling judged “*by the exception rather than the rule*” (p. 449). The contrast between CNMs and home-birth midwives’ understanding of birth¹⁵³ was very similar to the different opinions displayed by HMWs and SECMs in my study.

¹⁵² See the definition of transferability offered by Silverman (2010): concerned with the degree to which findings can be transferred to other groups or setting.

¹⁵³ In this study, CNMs refers to registered nurses who complete additional education and practice specific to midwifery. Home birth (or sometimes direct-entry) midwives are not nurses and in the USA have several options of education, including accredited and non-accredited schools, apprenticeships with home-birth midwives and apprenticeship at birth

Cheyney et al's study (2014a) used a multi-site ethnographic approach to explore the "*working relationships between midwives and physicians*" at home-to-hospital transfer in three states of the Pacific Northwest of America. These states were identified as having a long history of legal direct-entry midwives supporting home birth. Cheyney is a medical anthropologist and a home-birth midwife; her co-researchers included a doula and an obstetrician; observational data from their own experiences thus contributed to their study. Home-birth midwives (n=24) and hospital-based practitioners (n=16) were interviewed about their experiences. The hospital practitioners included obstetricians, certified nurse midwives (CNMs), perinatologists and general practitioners. While the researchers differentiate between the contributions of the CNMs and the physicians, they do not distinguish between the different medical professions of the group.¹⁵⁴ Factors that impede and support respectful interactions between healthcare providers at transfer were identified. The authors' discussions relate to the education and regulation of home-birth midwives; the concerns of obstetricians providing care to women who choose home birth, given that their professional organisation, the American Congress of Obstetrics & Gynaecology (ACOG 2011) does not support home birth; the fear associated with transfer (home-birth midwives' fear "... of being treated poorly, or women being treated poorly"); and hospital practitioners' fear of liability when they "*inherit*" the care of women from home (Cheyney et al 2014a, p. 451-452). Some of the findings and recommendations are culturally specific; nonetheless, very useful comparisons can (and will) be made to position the findings of my study in the socio-cultural understanding of birth in Ireland.

The next relevant study, that of Deborah Fox et al (2014), was published in summer 2014. They conducted a metasynthesis of qualitative studies exploring the experiences of women planning a home birth but requiring transfer to hospital during labour. Data from five studies contributed to this

centres. The status (legal) and registration of these midwives varies across the various US states.

¹⁵⁴ Given the different roles of these doctors and the focus of their 'normal' practice, this would have been interesting.

metasynthesis: Dahlen et al (2010c; Australia), Catling-Paull et al (2011; Australia), Creasy (1997; England), Lindgren et al (2011; Sweden), McCourt et al (2012; England). With the exception of Lindgren et al (2011), who conducted a nationwide population-based study exploring the effects that birth at home and transfer had on birth experience,¹⁵⁵ the other four studies were not focused specifically on transfer from home birth; however, data in relation to 8 of the women's experiences of transfer emerged in their findings. The themes of these studies were synthesised into three categories: "*communication, connection and continuity*", "*making the transition*" and "*making sense of events*", and will be compared and contrasted with the findings that have emerged from my study.

The manner in which I wrote Chapters 7 and 8 demonstrates that I chose to concentrate my writing first on the findings of this study. I did this to focus on the narratives within and across the participant groups, exploring the ethnographic story of transfer in as fluid a fashion as possible in a multi-sited ethnography, with four different participant groups. In keeping with the principles of the Voice-Centred Relational Method (VCRM) of data analysis and the recommendations of Mauthner and Doucet (1998), I wanted to bring their voices to the fore before introducing 'competing' stories from other research. Chapters 7 and 8 detailed also my responses to the narratives I heard and the stories I saw, thus emic and etic perspectives informed the emergent categories and sub-themes (See Appendix 7). In my adaptation of VCRM additional readings of sub-themes across the 4 readings allowed me to reconstruct themes where links were made between shared meaning, nuances and related ideas. These themes led to the 4 global themes I now position within the discussion of this thesis -

Women – from my space to their place.

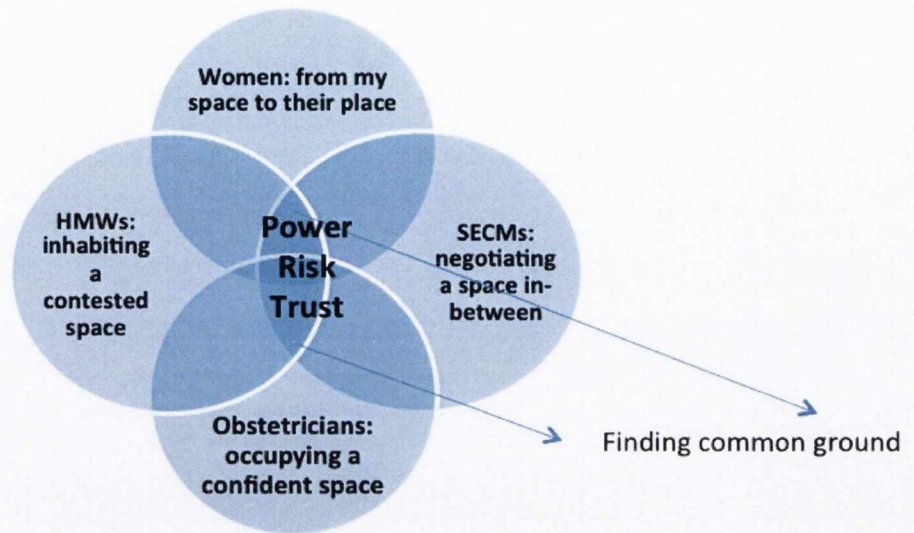
SECMs – negotiating a space in-between.

HMWs inhabiting a contested space.

Obstetricians – occupying a confident space.

¹⁵⁵ A total of 671 women, who had a home birth between 1998 and 2005, participated in this study; 95 women were transferred to hospital during labour, and 81 of these 95 women responded to open-ended survey questions about their experiences of transfer. These responses were analysed using qualitative content analysis.

Figure 4: Global Themes



I will now place the findings of my study, under these four headings, alongside the relevant literature and within the wider socio-cultural context of birth. In my final discussion I will synthesise the shared cultural expressions and variations across and within the participant groups, and explore possible explanations that will highlight their significance for understanding the interface of home and hospital birth in Ireland. This discussion informs the recommendations that I suggest will work toward finding common ground.

9.2. The Women – From My Space to Their Place

This study began with the premise that a small number of women in Ireland plan to birth their baby at home, and that some, in spite of their plans, will birth in hospital. The study explored how the women negotiated their crossing from home to hospital, taking into account the other key actors along the route. This study highlights that a key element in the women's experiences is the company they keep during the journey.

9.2.1 Challenging the Model of Maternity Care in Ireland

All the women who participated in this study planned a home birth. Women's perceptions of risk, trust and power influenced this decision, and

informed the way they viewed birth, whereby the women anticipated the model of care and healthcare professional that would best facilitate their needs, and that they would feel safe. *What the women wanted* and *what the women wanted to avoid* were the two main themes to emerge from the data in relation to choosing their place of birth. The findings relating to women's wishes for a say in their maternity care, and for continuity of carer, as well as a desire to evade the interventions of medicalised birth are similar to those reported in the international literature across Europe, Australia and the United States (e.g. Morison et al 1998, Edwards 2001, Viisainen 2001, Sjöblom et al 2006, Kontoyannis & Katsetos 2008, Boucher et al 2009, Lindgren & Erlandsson 2010, Jouhki 2012, Lothian 2013, Catling et al 2014).

Women in this study placed great emphasis on being supported by a healthcare professional whose understanding of birth mirrored their own. They assumed that within this relationship they would be facilitated in their choices and supported to have a normal birth. Women's stories reveal that it was not just birth at home they wanted; they also identified as crucial in their experiences the SECM's approach to providing personalised care and the time they spend developing their relationship. Continuity of care with a known carer, as clichéd as it may sound, emerged as a determining factor for women when choosing a model of maternity care. Over twenty years ago, the benefits of continuity of care and carer were espoused at the strategic planning level of the maternity services in the UK in the form of '*Changing Childbirth*', as the Cumberlege Report (Department of Health, UK 1993) was more commonly known. It recommended the reorganisation of maternity services to ensure that care was woman-centred and focused on women's needs. It also endorsed the importance of continuity of care (McIntosh 2013). The most recent Cochrane systematic review of midwife-led continuity models versus other models of care highlights that continuity of midwifery care facilitates safety through relationship-based care (Sandall et al 2013). The women participating in the present study wanted relationship-based care; wanted to know their midwife; wanted a midwife who agreed with their understanding of birth, and wanted a midwife who would support their desire for a normal birth. Planning a home birth with an

SECM was seen as the best way within the current provision of maternity care in Ireland to guarantee these wishes; some of the women perceived that it was the only way. There is considerable evidence about the benefits associated with a known midwife supporting women in labour (e.g. reducing the need for pharmacological analgesia and increasing the likelihood of women stating their satisfaction with their birthing experiences (Sandall et al 2013). Sandall et al (2013) highlight the value of midwife-led models, and building a relationship with women, as central to the organisation of care. Yet, for many women in Ireland such an option is not available. Even the women in this study, who had planned to birth at home, spoke of their challenges in securing an SECM, and of the *ad hoc* availability of home birth. They questioned the lack of choice available to them and suggested that this demonstrated the low value that the HSE and Department of Health place on offering women in Ireland alternatives to hospital-based birth.

These women did not want to birth in hospital. They considered the attention and interventions of obstetric medicine unnecessary for normal pregnancy and birth. Birth in hospital was viewed as a source of risk owing to women's perceptions that more interventions in labour were likely to occur there. Some suggested that routine interventions added to complicated labour experiences, in the sense that one intervention begets another. A similar finding equating unnecessary medical intervention with reduced safety emerged in Boucher et al's (2009) study. The women in my study did not trust, in fact they feared that they would not be in a position to avoid the powerful routines of medicalised birth and the protocols of managed labour if they birthed in hospital. They feared that their voices would be silenced if they became just another woman within the routine of hospital birth. This fear was not unfounded given that labour wards in maternity hospitals have been criticised in the past, with women drawing attention to their 'baby factory'-like character (Walsh 2006). In these environments women are moved along an industrial model of care with little thought for their individual needs (Devane et al 2007) and their 'choices' facilitated within the institutions understanding of birth (Jomeen 2007).

A unique finding of this study is that a cohort of these women chose home birth not because this was their desire *per se* but because they did not want hospital-based obstetric care, and no other option (e.g. birth centre / midwife-led unit) was geographically available to them. This is in spite of the ample evidence, including the MidU study conducted in Ireland (Begley et al 2011), indicating the safety of midwife-led units of maternity care (e.g. Hartz et al 2012, Tracy et al 2013). For these women home birth was a default choice. Although midwife-led care was offered, in varied forms, in some of the maternity hospitals, the women in this study did not think such claims were credible; they questioned the HMWs' ability to provide midwife-led care within the environment of medicalised birth. Rhona O'Connell's doctoral research explored the construction of childbirth within an obstetric hospital in Ireland (O'Connell 2011). Based on her findings she proposed that HMWs find ways to resist obstetric norms, thus supporting normal physiological birth within the confines of hospital-based care. However, women in my study were not aware, nor did they believe, that midwife-led care could exist in such environments. Such perceptions have consequences for the future development of the maternity services in Ireland and must be considered in the organisation of midwife-led care (current and future models).

In her attempt to explain why women choose to avoid the culturally acceptable model of obstetric-led care and the routine interventions associated with managing birth, Cheyney (2008, p. 262) applies the term "*system challenging praxis*".¹⁵⁶ Cheyney suggests that women critique and challenge medicalised care in hospitals and look to alternative understandings of birth. Choosing home birth is an indication that they support the alternative understanding. Given the narratives of the women in my study, it is likely that they followed a similar process. It was necessary to explore these ethnographic descriptions grounded in the women's home-

¹⁵⁶ Derived from the anthropological work of Singer (1995) who uses the term "system correcting praxis" to describe changes that have been made to hospital birth in the late 21st century (e.g. having home-like décor, ensuring the bed is not the focus of the labour room, removing any medical equipment from sight) in an attempt to underplay the role of obstetrics and management of labour in women's experiences of birth. While these changes to practice are beneficial, it is suggested that they in no way challenge the dominant discourse of obstetrics.

birth narratives. This served to illuminate the specific understandings of birth that the women rejected and those they accepted, and thus provide a clear context in which transfer to hospital occurred for these women.

9.2.2 Impressions and Interactions During Antenatal Care

In-depth stories were offered about interactions with healthcare professionals during the women's antenatal care; these recounted both support of and challenges to their choice of home birth. In the supportive cases, women focused their attention on the relationship they developed with their SECM and how encouraged and safe they felt within this approach to care. Levy (2004) claims that, when women know their midwife and trust in her level of competence, they begin to feel a sense of security. This contrasted with interactions with hospital-based practitioners during which women were left in no doubt that planning a home birth transgressed the cultural understanding of birth in Ireland. Confrontational interactions (in the main) further entrenched their already negative perceptions of birth in hospital and added to the women's steadfastness about avoiding engaging with those who did not support their understanding of birth. Repeatedly, hospital-based practitioners challenged the decision to birth at home, citing their perceptions of safety and risk as the factors that should inform women's decisions. Little account was given to women's different understanding and their perception that hospitals and routines of intervention were unnecessary in normal birth. Similar findings are reported in Edwards (2001); women planning a home birth in Scotland faced dismissive reactions from healthcare providers in relation to their interpretation of risk and how this influenced their choice of home birth. Cheyney (2008) suggests that women planning a home birth in America commonly face challenges to their decision to birth outside the culturally accepted norm. The hospital-based participants did not report an awareness of this issue or a realisation that they could further alienate women during antenatal interactions. This indicates that the current process of antenatal referral and engagement is not adequate and requires review.

Recurrent, in the problematic experiences during antenatal care and not reported in the literature in this context, were women's concerns about the

power held by obstetricians and the worry that they would find a reason to state that home birth, for them, was no longer an option (and thus endanger the legal legitimacy of the MOU¹⁵⁷). Any confrontational experiences led women to appease hospital-based practitioners during subsequent interactions. The women spoke of their attempts, in order to resist the obstetric hegemony, to avoid any scenario that in any way threatened their home birth. They did not openly challenge, even when they disagreed with, the authoritative obstetric knowledge. In some cases they stopped telling the hospital-based practitioners¹⁵⁸ that they were having a home birth, thus not giving anyone an opportunity to criticise their plans. The feeling that they could not talk to hospital practitioners about their plans in spite of the evidence that demonstrates the safety of planned home birth for healthy women (Olsen & Clausen 2012, Brocklehurst et al 2011, de Jonge et al 2013, Janssen et al 2009) raises concerns. Lindgren et al (2010) note that women in Sweden avoid discussing any risks of home birth with healthcare professionals who they believe will not support their choice. However, unlike the women in Ireland, they do not fear that those who disagree are in a position to cancel (“*take away*”) their home birth. I suggest that the current construction of the MOU and the non-consultative process adds to this concern. By this I mean that an obstetrician can decide that a woman no longer fits the criteria of the MOU without an obligation to seek the opinion of other healthcare professionals (including the SECM). Nor is there room within the current operationalisation of the MOU to negotiate a pathway of care (e.g. a combination of models) specifically to meet women’s needs. This leaves little opportunity for collaborative, woman-centred care.

Experiences of confrontations during pregnancy placed the maternity hospital and healthcare professionals therein in a negative light. The women assumed that this negative response to them and to home birth would continue into transfer to hospital. Only a third of the women recalled antenatal interactions that made them anticipate a supportive interface between home and hospital birth should transfer occur. A positive

¹⁵⁷ An invalid MOU meant that the SECM was no longer in a (legal) position to provide care.

¹⁵⁸ E.g. when they attended hospital clinics for ‘routine bloods’ as per the requirements of the MOU.

interaction was assumed when there was a respect for the women's decisions regardless of the practitioners' opinion of the appropriate place to birth. These women enjoyed enthusiastic responses to their plans for home birth, and some were introduced to and shown around the hospital 'just in case'.¹⁵⁹ Positive interactions at transfer were anticipated by women in a study carried out by Catling-Paull et al (2011) to explore women's choices and experiences of publicly funded home birth in Australia. This home-birth model was offered as part of the services of a local maternity hospital. Women had some of their antenatal visits within the hospital; therefore, they felt they were connected to it. The hospital was viewed as a "*safety net*" (Catling et al 2014, p. 896) by these women, something to be relied on rather than feared or avoided, as women in my study suggested. It was SECMs who were seen as the *safety net* by the women in my study.

9.2.3 Surprises of Labour

All the women spent some time labouring at home. Labour and birth stories were recalled in great detail. Over half of the women told of unanticipated features of their labour. These "*I didn't expect*" comments related mainly to pain and the length of labour. Dahlen et al (2010a, 2010b)¹⁶⁰ describe a theoretical framework of "*novice birthing*" where primiparous women (who accessed home and hospital birth in Australia) recalled "*reacting to the unknown*" during labour (Dahlen et al 2010a, p. 56). Diverse narratives were offered by the women in this Australian study; however, how they processed their experiences of labour and readjusted their expectations depended on the levels of preparation, choice, control, information, communication and support they perceived within their midwifery care. Nearly all the women in my study were extremely positive when describing the care they received from their SECM and how prepared they felt they were for birth. Nonetheless, elements of their labour took them by surprise and at times led them to doubt the normality of their experiences. This warrants further investigation.

¹⁵⁹ An exercise they found positive.

¹⁶⁰ This study explored how 17 women negotiated birth. The sample included 15 primiparous women (8 birthed in hospital, 2 in a birth centre and 7 at home) and two multiparous women (1 birthed at home, the other in a hospital).

9.2.4 Transfer, Trust in the Decision

The findings of this study highlight how women deconstruct their experience of transfer. They look at why it happened, how they felt about transfer in the moment, how they feel about transfer after the event. The women highlighted their disappointment in relation to transfer; while some felt a sense of relief at the time of transfer, all expressed some disappointment when they compared their expectations and plans to their subsequent experiences. The decision to transfer (most of the women in this study did not experience an urgent transfer to hospital and had time to discuss all issues with their SECM) was negotiated between women and SECMs in the context of a pre-established relationship that was based on a shared understanding of birth. With the exception of two women who instigated transfer themselves, the SECM and women were in agreement. While the women demonstrated disappointment in relation to transfer, none of them objected or suggested that it was a decision they disagreed with; they trusted the opinion of their SECM. The findings of Fox et al's (2014) metasynthesis also made reference to trust. As with the women in my study, trust existed in relationships where the midwives were well known to the women, in relationships where there was continuity of carer. Once again, this highlights the benefits of the one-to-one relationship that is central to the home-birth model of care.

9.2.5 Positive and Not-so-positive Interactions at Transfer

In keeping with the diversity shown in other parts of the ethnographic stories, the interactions at transfer varied for the women, and were greatly influenced by the construction of birth held by the hospital-based practitioner they met. Women in this study told, and I observed, interactions that facilitated a seamless interface between home and hospital birth. However, most meetings involved some negativity.

In the positive experiences, women described meeting HMWs who were supportive of home birth (or at least did not have major concerns in relation to its appropriateness as a model of care), supportive of the SECM and supportive of normal birth. Women felt that their plans for home birth and a

natural experience were acknowledged and facilitated as far as possible. They felt included in the decision-making process even when their expectations of birth were not realised or when interventions, previously unwanted, formed part of their care. These encounters mirror the positive interactions recalled by the women in Catling-Paull et al (2011). Negative interactions were grounded in an atmosphere of suspicion. Diverse understandings of birth were evident in these encounters and judgements were made by each participant group about the other. Women in Lindgren et al's (2011) study in Sweden (n=81) were also confronted with negative interactions that they considered challenging. In these interactions, power and trust emerged as significant themes. Many of the women did not have faith in hospital practitioners and attempted to challenge the necessity of some of the care measures they proposed. However, in these moments of disagreement women felt that the power was firmly held by HMWs and obstetricians, and that they set the tone of the interactions. In many of the encounters, women thought, the healthcare practitioners did not approve of their choice of home birth and therefore had little regard for their plans and feelings of disappointment when they transferred to hospital. Women said that hospital-based practitioners did not acknowledge or listen to their wishes for birth. Dahlen et al (2010c) propose that it is important for women to acknowledge feelings of disappointment, to acknowledge their sense of loss in relation to transfer to hospital. The women in my study wanted this to be acknowledged by the practitioners they met in hospital and to be taken into consideration when offering care. They did not think this was apparent in their experiences. The women considered hospitals to be the domain of HMWs and obstetricians, with hospital-based practitioners deciding that their version of the *correct* pathway of care was needed. During these encounters, women suggested, they had little choice and had to "*do what I was told*". These findings provide striking examples of disciplinary power at play within hospital birth that affected women's experiences. I will return to this issue of power in section 9.6.

Recurrent themes in the problematic experiences were stories of birthing with strangers, mistrust of the healthcare practitioners' intentions, and feeling that care was no longer tailored to meet women's specific needs. In

these interactions, women felt that they were persuaded to accept a particular route of medicalised care, often because it met the routines and needs of the hospital. Torres and de Vries (2009) propose that such maternity-care systems, using routine interventions and ‘assembly-line care’, raise huge bio-ethical issues. I argue that the maternity system in Ireland can no longer be guided by the production line, but needs to focus on the individual needs of individual women.

9.2.6 Guarding Birth

The presence of the SECM at transfer (and during the remainder of labour) was identified as one way to overcome negative aspects of transfer. As with care during pregnancy and labour at home, continuity of carer was identified by women as the most positive influence on their experiences of transfer. Having their SECM with them in hospital, the midwife they knew and trusted, who was aware of their expectations of birth, was important for them. This echoes the findings of McCourt et al (2012); the women in their interviews noted that the presence of their midwife after transfer supported them to remain “*focused and in control of the situation*” (Mccourt et al 2012, p. 8). Women in my study found the presence of their SECM beneficial not only because of the ongoing support and encouragement that their SECM provided, but also because they believed that the SECM would protect them; would ensure that the hospital-based staff did not stray from the woman’s wishes or carry out any intervention that was not completely necessary. This throws into sharp relief the women’s distrust of HMWs and obstetricians, and raises concerns in relation to women’s perceptions or past experiences of care in maternity hospitals in Ireland. Although continuity of care emerges as a finding of Fox et al’s (2014) metasynthesis, the need for continuity of *carer* to ensure protection from hospital-based staff is unique to the findings of this study. Even when home birth was no longer a possibility the SECMs, in Ireland, had a significant role to play in guarding the women’s experience. The most apparent barrier to a positive experience, for the women in this study, was when their SECM was not allowed to stay following transfer. Women surmised that the way they felt about their birth story and how they were treated in labour could have been more positive if their SECM had continued to offer care and acted as a buffer between them

and hospital birth protecting them from the routines of hospital care. The participants of Lindgren et al (2011) also raised this issue, and even in their positive stories stated, for example, *“I just wished that my home birth midwife had been allowed to stay with me”* (Lindgren et al 2011, p. 103). There is no doubt that the women in the present study regarded the ongoing presence of their SECM at and after transfer as a strong source of support. This must be reflected and accommodated in the organisation of maternity care in Ireland.

9.2.7 Locating Safety in Individuals, Not Routines

An overwhelming theme of women’s stories lay in the unpredictability of their experiences of in-labour transfer. Influenced by their previous encounters and experiences with healthcare practitioners, they had preconceived ideas of the way their story would unfold. However, given the current organisation of maternity services in Ireland, women could not foretell the HMW (or obstetrician) they would encounter in the hospital. The idea that *“it’s all who you meet”* was pivotal to their interpretation of their experiences at the interface of home and hospital birth. These women did not have a sense of belonging to a maternity-care system, as noted in Catling-Paull et al (2011) and Catling et al (2014). Arising from their metasynthesis, Fox et al (2014, p.114) advocate that women should gain familiarity with the *“personnel, processes and environment of the backup hospital”*, suggesting that this provides women with more realistic expectations if transfer is needed. This was also suggested by the HMWs in my study. However, as some of the experiences and narratives to emerge from this ethnography highlight, gaining familiarity with hospitals, in the context of the current dominant discourse of birth in Ireland, runs the danger of obstetricians and HMWs initiating a ‘persuade them to our way of thinking’ exercise, rather than truly working with women to meet their needs. Familiarity and integration are necessary, but this should not be led by the obstetric discourse of risk and governed by the routines of medicalisation of birth.

Women highlighted significant differences between their experiences of labour at home and in hospital. They recalled that at home it was *their*

experience; that they had a voice in the way care was offered. Their narratives demonstrate that this was important to them. At home, women considered that the care they received truly focused on them and on their needs. The women highlighted feeling safe with their SECM, holding her knowledge and practice in high regard. Almost all of the women made it clear that safety and trust were embedded in their relationship. Home birth and the care provided by SECMs remained revered as *the* model of care by the women¹⁶¹ in this study, even by those who birthed in hospital. Women in Catling-Paull et al (2011) and Lindgren et al (2011) displayed similar feelings, and were determined that their next birth would be at home. In making sense of their birth stories, the positive and the not so positive experiences, women in my study held fast to their belief that labouring at home, for any length of time, was beneficial. They suggested that home birth gave “*labour a chance*” and staved off the early routine interventions they associated with time restrictions in hospital and measurements of progress of labour. This contrasted greatly with the way care in hospital was described by many women. These women felt little ownership of their experience, and that they were subjected to the routines of medicalised birth with little regard for their individual needs. In these stories women said the experience was not theirs, it “*belonged to the hospital*”.

The women in this study located safety in individuals; this emerges from all aspects of their stories and contrasts with the view of the hospital-based practitioners who located safety in the routines of institutions.¹⁶²

9.3 The Self-employed Community Midwives – Negotiating a Space in Between

The SECMs in this study are in a unique position in that they practise under the terms and conditions of the MOU as set down by the HSE, yet remain self-employed. They are part of a national service that supports home birth; however, they are not employees of the HSE. This differs from configurations of care in other jurisdictions and brings with it dilemmas influenced by the cultural construction of the health service in Ireland.

¹⁶¹ All but three women were definite in this view.

¹⁶² I will return to this point in Section 9.6.3.

However, as noted in Section 9.1.1, the SECMs' experiences and those of the home-birth midwives of northwestern states in the USA recorded in Cheyney et al (2014a) are surprisingly similar, in spite of the fact that the home birth midwives and home birth operate independently from the healthcare system in America.

9.3.1 Being a Midwife

The SECMs understand birth as a normal, physiological event that does not routinely require the interventions of medical management that are commonplace in maternity hospitals in Ireland. All these midwives stated that being an SECM was their only opportunity to act in their full capacity as a midwife outside the constraints of obstetrically-managed labour. Previous studies conducted in Ireland (Hyde & Roche-Reid 2004, Keating & Fleming 2009) explored the role of the midwife in obstetric-led units and highlighted that the culture of medicalised birth within hospital environments makes it challenging for midwives to fulfil their role as a midwife, as defined by the International Confederation of Midwives (most recent definition: ICM 2011), and to provide midwifery care that is not supervised and directed by obstetric practices. Midwives in other studies (e.g. Keating & Fleming 2009, Fenwick et al 2012) describe their belief that they have to work outside the dominant culture in order to promote normal birth. Several findings of the present study, across participant groups, call into question the role of the midwife and the discord between the definition of the autonomous midwife as noted by the ICM (and upheld by the Nursing & Midwifery Board of Ireland) and the actuality of midwives in practice.

The continuity of care and carer so important in women's experiences was also held as important by the SECMs. They acknowledged the benefits for women and also expressed the professional satisfaction they felt when they developed a relationship with women and supported women in the planning of, preparation for and care during pregnancy and birth. Many of the SECMs commented that midwifery practice organised within this model of care made them feel "*like a midwife*". Other midwifery studies (Sandall 1997, Walsh 1999, Hunter 2004, Hunter 2006, Kirkham et al 2006,

Olafsdottir 2006, Walsh 2007) have demonstrated that increased job satisfaction is associated with holistic and caseload models of maternity care when compared to the fragmented hospital-based models. However, as noted in Chapter 4, options for midwives in Ireland to work within midwife-led models of care are limited; the fragmented 'traditional' models remain the predominant template for midwifery in Ireland. The impact that this organisation of care is having on both midwives' work and women's birth experiences needs to be explored.

9.3.2 Caught Between Women and Regulations

This continuity of carer and the relationships that developed with women therein, located in a shared understanding of birth, were deemed vital by the SECMs to ensure smooth negotiation of the decision to transfer. None of the SECMs gave personal examples of conflicts with women who did not want to transfer; instead they talked of negotiating and planning transfer in the context of a trusting relationship.¹⁶³ This contrasts with the findings of Wilyman-Bugter and Lackey's (2013) phenomenological study exploring the experiences of 10 community midwives during transfer from home birth to hospital care. The community midwives¹⁶⁴ in Wilyman-Bugter and Lackey's (2013) study highlighted disagreements with women when they recommended that transfer was needed. The midwives were part of a community team and worked according to a shift-duty roster as opposed to being the sole midwife providing one-to-one care. They suggested that continuity of care and antenatal preparation focusing specifically on unplanned transfer were necessary if conflicts in relation to care were to be minimised. Although they did not refer to experiences of disagreement or women choosing not to transfer, the SECMs were aware that this was very possible. In these scenarios, they suggested, SECMs were (as a result of the MOU and the Nurses and Midwives Act) in a contradictory position. They were legally obliged not to provide care outside the MOU but morally

¹⁶³ The obstetricians remain unconvinced and suggest that SECMs move their "*professional goalposts*" and step outside their Scope of Practice in order to accommodate women's wishes and thus delay transfer to hospital.

¹⁶⁴ This study explored midwives' experiences of home-birth transfer to hospital. The participants of the study (n=10) were part of the community midwifery team employed by a National Health Service (NHS), UK trust. These midwives rotated between the community and the local obstetric unit.

obliged not to leave a woman unsupported. This caused great concern for these healthcare professionals. OBoyle's ethnography of 'Independent Midwifery' in Ireland (OBoyle 2009) notes the dilemma this raises for SECMs and highlights the tension between supporting women's autonomy and conforming to professional regulations. Midwives in the UK have also raised concerns over increasingly rigid protocols guiding home birth and the lack of support and disciplinary consequences for midwives who wish to support women who fall outside the set criteria (Edwards et al 2011, Kirkham 2011, Kirkham et al 2012). The SECMs in the present study said that they had raised with the HSE the issue of their professional vulnerability, being caught between women and the health services again and again, with little progress (personal communication, chairperson of the Community Midwives Association, August 2014). This is an unacceptable situation that warrants urgent review.

9.3.3 Framing the Decision to Transfer

The SECMs spoke at length about the decision to transfer to hospital. While disappointed for the women, they were pragmatic in their reactions. While accepting pregnancy and birth as a normal physiological event, all midwives noted that in some situations deviations from normal occurred and hospital became a more appropriate venue for birth. This possibility was not disputed by any of the SECMs. However, they did not hold that all the reasons for transfer stipulated by the MOU were necessarily appropriate and suggested that they were constructed as rules rather than guidelines for practice within the context of individualised care. Interestingly, while the community midwives in Wilyman-Bugter and Lackey (2013) called for home birth and transfer protocols to guide their practice, SECMs in Ireland believed that the guidelines they have, in the form of the MOU, restrict their practice and their professional autonomy. Given the concerns raised by the SECMs in relation to the MOU and the strong influence that it has on their practice, a call for their involvement in a revision of the agreement is justified.¹⁶⁵

¹⁶⁵ Personal communications with members of the CMA indicates that, while they were invited to give feedback to a revised draft of the MOU in 2013, they do not consider this a consultation process and remain unhappy with elements of the agreement.

9.3.4 Building Bridges Across Suspicion and Mistrust

Trust and mutual respect, a feature of the SECM relationships with women, was not evident in the interactions with hospital practitioners recounted by most of the SECMs. In many cases the SECMs said they were viewed with suspicion. They felt that HMWs and obstetricians considered home birth and their midwifery practice at home birth to be risky. SECMs said that this questioned both their professional and personal integrity. On transfer to hospital, SECMs were regularly challenged by hospital-based staff. In their experiences, these challenges were often based on isolated facts of the transfer rather than an awareness of all issues concerning the labour or acknowledgement of the appropriate care (including transfer) that they had instigated. The SECMs stated that most frequently the protocols of actively managed labour were held aloft as the standard against which their practice was judged, which they considered inappropriate. Davis-Floyd (2003) and Cheyney et al (2014a) identify very similar issues for the home-birth midwives in their studies. In both studies the midwives felt that the hospital-based staff assumed that they had made poor decisions, and that this frequently meant that they were blamed for transfer or that they had exacerbated the complication. Using a very similar phrase to the participants of my study, the home birth midwives in Cheyney et al (2014a) suggested that they felt judged by “*the exception and not the rule*” (p. 450).

The SECMs spoke at length of their professional vulnerability when faced with the judgements and negative reactions of hospital-based practitioners. The judgements of hospital staff had two immediate consequences. If hospital practitioners considered SECMs and their practice ‘risky’ and disagreed with their care decisions, they would be excluded from any ongoing role in supporting the women during their labour. SECMs also believed that hospital-based practitioners would instigate a disciplinary procedure with the NMBI or governance structures with the MOU. The basis of these complaints was thought to lie in different readings of safety and risk. In these narratives, the professional isolation felt by SECMs clearly emerged in that they felt unsupported by obstetricians and most hospital midwives. Edwards et al (2011) and Kirkham et al (2012) highlight

similar anxieties among independent midwives in the UK and their unease about the judgements made by healthcare professionals who were not aware of the subtleties of independent midwifery practice (Davies 2009, Edwards et al 2011 and Kirkham et al 2012). The SECMs took that point even further; they suggested that HMWs have forgotten the subtleties of normal birth. While this may be held as an unjust assertion, the findings across the participant groups would give some merit to this allegation. I will advance this point in Section 9.6.2, drawing on understandings of risk, and highlight its impact on the development of the maternity services.

In an effort to diminish potential confrontations in the interactions at transfer, some of the SECMs referred to strategies to earn credibility and gain the acceptance of hospital-based practitioners. By integrating themselves, SECMs suggested that they gained credibility with the hospital staff, and that this enhanced their interactions at transfer. In their experiences of working in local hospitals, these SECMs suggested, they had already demonstrated that they were safe and competent practitioners. Home birth midwives who contributed to Davis-Floyd's (2003) anthropological research of birth in America make reference to the efforts of home-birth midwives to build relationships with obstetricians and certified nurse midwives (CNMs; HMWs). In their experience, establishing a 'good' reputation in the hospital led to mutual respect and cooperation at time of transfer. This plays out to a certain extent in my study; SECMs considered credible were often allowed to remain with women in hospital and contribute to aspects of their care. However, even when accepted by hospital staff, the SECMs conceded, their presence in hospital and the role they assumed was governed by HMWs and obstetricians. They acknowledged the constraints that this presented but proposed that being with the women, even on restricted terms, was more beneficial for the women than the alternative. Davis-Floyd (2003, p. 1917) refers to the "postmodern midwife", a midwife who balances the knowledge systems of home and hospital birth, and engages strategically with hospital midwives and obstetricians. While the SECMs hold this as ensuring a space of cooperation, allowing them the opportunity to support women in hospital and subtly instigate changes in attitudes to normal birth, Lane (2002, p. 26)

suggests caution to ensure that this 'hybrid' midwife is not subsumed into the medical understanding of birth in an attempt to gain acceptance. Regardless of which reading is subscribed to,¹⁶⁶ my study highlights that SECMs were negotiating with women during labour while simultaneously negotiating their professional credibility within a healthcare system that views their practice as risky.

9.3.5 Negotiating Positions in the Maternity Services in Ireland

The findings of this study demonstrate that SECMs have to negotiate their position within the organisation of the maternity services in Ireland. In spite of the role they play in a named National Home Birth Service as supported by the HSE, they remain on the margins of the provision of maternity care, and for the most part are treated with suspicion by hospital-based practitioners. Their experiences at in-labour transfer demonstrate clearly their professional vulnerability and how this vulnerability constrains and influences their midwifery practice. Their resistance to and dissatisfaction with the cultural construction of power within the organisation and provision of maternity care in Ireland remain indirect and subtle in the interactions at transfer in an effort to subvert the medical model in a non-confrontational way. The SECMs claim that past events have shown them that this approach is needed to ensure that they are permitted to support women, in some way, during transfer. They also deem it necessary to safeguard their role as an SECM and ensure that their professional competency is not questioned and their practice is not restricted. This position is supported by Cheyney et al's (2014a) assertion that home birth midwives strive to be accepted by hospital practitioners out of necessity (it is true that SECMs will always need the support and backup of hospital staff, but the hospital-based staff in this study showed no evidence to suggest that the reverse situation applies). Davis-Floyd (2003) proposes that the dominance of obstetric discourse has meant that midwives are forced to engage with obstetricians in a manner that the doctors consider appropriate and that conforms to their particular understanding of birth. The SECMs echo the home-birth midwives of Davis-Floyd's anthropological work, who deem acceptance necessary to enhance the potential of having a

¹⁶⁶ I can see the merits of both positions.

collaborative and positive interaction at transfer. This negotiation, rather than confrontation, with power is understandable, because that power is so hugely dominant. It could also be suggested, however, that subtle resistance and engaging with doctors on their terms does little to challenge the structures of obstetric discourse that underpin the organisation of the maternity services in Ireland, and that therefore, for the most part, the status quo remains.

9.4 The Hospital-based Midwives – Inhabiting a Contested Space

Consistent with the findings concerning the women's experiences of in-labour transfer, the healthcare practitioners' experiences were diverse. While some overlapping themes between the midwives (SECMs and HMWs) were noted, there were also significant differences in their views, such as the emphasis HMWs placed on the protocols and procedures of active management of labour and the compliance they demonstrated with obstetric-led care and cultural norms.

In their narratives, the HMWs demonstrated a cultural duality in that they voiced their commitment to the ideology of normal birth and home birth, but, in their interactions with women and with SECMs, most of them showed that they understood birth within the obstetric discourse of surveillance and risk. O'Connell and Downe (2009) conducted a metasynthesis of midwives' experience of practising midwifery within hospital settings in Ireland, Wales, England, Norway and New Zealand. One of the findings was that midwives often espouse the rhetoric of woman-centred care and supporting normal birth, but that, in practice, their care is grounded in obstetric discourse and medically-managed labour.

9.4.1 Cultural Duality in Midwifery Practice

The HMWs recalled some positive stories of transfer. In these scenarios the midwives (HMWs and SECMs), often knew each other and therefore had a relationship that predated the interaction at transfer. In situations where the SECM and her practice were viewed as reliable by the HMWs (reliability was judged not only by knowing the SECM, but also by her reputation), experiences of transfer were held as unproblematic. The women came to

hospital and were supported to birth without scenes of disagreement or confrontation; a smooth interface between home and hospital was demonstrated. Similar accounts of positive experiences are noted by Davis-Floyd (2003) and Cheyney et al (2014a). Yet these positive experiences were not the main focus of the midwives' stories in the published literature or in my research. The findings of my study are that HMWs put most emphasis on negative interactions. These are the interactions that live on in their understanding of home birth.

The findings from interviews with HMWs show that their perceptions of home birth, of SECMs and of transfer were based mainly on accounts that have become part of the hospital 'conversation'. Most of the HMWs admitted that their experience of home birth was very limited and was often informed by stories they had heard from other practitioners in the hospital. Certain SECMs have a 'bad reputation', leading HMWs to dread any encounters with them; they anticipated that interactions with women and SECMs would be difficult and challenging: difficult, because they expected poor outcomes for women and their babies as a result of the care at home; challenging because it was assumed that women and SECMs would not engage with the care practices HMWs had to offer. The CNM participants of Cheyney et al (2014, p. 448) also referred to "*good and bad midwives*"; bad midwives were viewed as those who disagreed with all aspects of hospital birth and encouraged women to decline every intervention.

9.4.2 Locating Safety in the Routines of Hospital Birth

The hospital-based practitioners in Cheyney et al's (2014a) study made reference to disagreeing with the care offered by home birth midwives and some of the decisions they made. This also emerged in my study; the HMWs cited their frustrations relating to the SECMs allegedly not providing appropriate care. As I have noted in several parts of this thesis, this judgement was most frequently informed by the HMWs' belief that the protocols and guidelines offered by the hospital should inform the practice of all midwives. Some of the HMWs were aware of their negative reactions to and their judgement of SECMs' practice at transfer. They made little or no reference to the fact that similar scenarios arise in hospital birth. The

HMWs did not indicate that they consider that care in hospital and medically-managed labour can contribute to complications during labour and birth. Beech (2009a and b) suggests that hospital practitioners automatically blame the practice of home birth midwives if there is a poor outcome; this contrasts with their reactions to tragedies in hospital, when it is assumed that best practice was provided and that the outcome was unavoidable. Stephens (2005) deems it unfair that, in the debate about place of birth, the “burden of truth” is on the advocates of home birth. This clearly emerged also in the findings of my study; women and SECMs were required to convince hospital-based staff that their support for home birth was not an ideal based in nostalgia and fallacy.

The HMWs’ frustrations with home birth lay not only in their views on some of the decisions made by SECMs but also in their critiques of the SECMs’ handover of care; they cited incomplete documentation or poor recall of the order of events during an emergency. This also emerged as a huge concern for the participants of Cheyney et al (2014a). The HMWs in my study suggested that poor communication of significant information and confusion about the chronological order of events led to disjointed handover. For the participants of Cheyney et al (2014a) it was slightly different, in that their concerns lay in the terminology that home-birth midwives used and cultural differences in relation to what they documented and what hospital-based practitioners deemed appropriate.¹⁶⁷ The challenge for these hospital-based practitioners lay in their reading of the woman’s case notes; reference was not made to a verbal handover.

In their interactions with women, the HMWs in this study felt that women blamed them when their birth plans were not in keeping with their expectations. These midwives perceived that the care and interventions they implemented were necessary, but that women did not always believe that. The obstetricians in this study also believed that women held hospital staff responsible for interfering with and denying them their plans. This is not

¹⁶⁷ These CNMs suggested that the home-birth midwives focused more on the women’s feelings and emotional wellbeing than on the physical observations and measurements the CNMs deemed important.

reflected in the literature in relation to home birth transfer. The HMWs professed sympathy for the women in these situations; however, they, and the obstetricians, felt that the cause of the disappointment lay in the women's unrealistic expectations of birth. SECMs were blamed for not ensuring that women were realistically prepared for all eventualities of pregnancy and labour. The hospital-based participants of Cheyney's study did not refer to women's unrealistic expectations of birth, but recalled positive interactions at transfer when the home-birth midwives did "*an excellent job of preparing their patients for the hospital*", thus making "... *mothers more compliant*" (Cheyney et al 2014a, p. 449). Stapleton et al (2002) term this "informed compliance". Women are prompted to make the 'right' choice, with little regard for their role in the decision-making process. The HMWs were aware that women did not routinely trust them when they transferred to hospital; they offered two reasons for this. First, they were not known to the women;¹⁶⁸ secondly, the women had not planned to birth in hospital. The hospital-based practitioners suggested that any encounter was going to be problematic because of this. The HMWs spoke of the time they spent attempting to gain their confidence. A number referred to the need for them to cajole the women (the Irish word *plámás* was used), in order to bring them around to their way of thinking and convince them to consent to the care the hospital deemed necessary. This is an area for consideration for future research as it is a strategy that contrasts with the open and trusting relationship that the women and SECMs in this study subscribe to. This strategy also implies that the HMWs seek to persuade women along a particular pathway of care rather than supporting their ability to make an informed decision.

9.4.3 Deconstructing Midwifery

HMWs were aware of the close relationship that the women had formed with their SECMs. Some of them suggested that it was beneficial for elements of that professional relationship to continue after transfer and, in some cases, allowed to remain with the women. The HMWs were quick to

¹⁶⁸ This contrasts greatly with the relations these women had with their SECM; however, due to the organisation of care in maternity hospitals in Ireland, meeting a woman for the first time during her labour is not unusual. In a sense HMWs are accustomed to this, but some are aware of the associated limitations.

point out that that the SECMs could act in the role of support (e.g. like a doula) but that the obstetricians were now the lead caregiver, and therefore the SECMs were no longer in a position to determine the care pathway. Collaboration, whether inter- or intra-professionally, did not feature in these discussions. Some HMWs suggested that it was acceptable for SECMs to remain with women after transfer; the SECM could offer “*support*” while they (HMW) “... *did the midwifery ... managed the labour*” (see 8.8.1.2).

These findings indicate that the organisation of maternity care in Ireland in the second decade of the 21st century remains in keeping with a “*production*” (Beddall & Carr 2010) or “*assembly*” line (Walsh 2006) within the industrial model of managed birth exemplified by active management of labour (Kirkham 2010). Walsh (2010) draws similarities between this approach and the industrial model of Fordism, with the breaking down of labour and birth into component parts and assigning each worker to a specific task. Task-orientated rather than woman-centred care was demonstrated in some of the stories told. This approach illustrates features of the “*Technocratic Model of Birth*”, (Davis-Floyd 1994), and again demonstrates how the HMWs (in this study) have reconstructed normal birth and accepted the medical model of birth, with its components of routine measuring and monitoring as normal. This approach differs greatly from that of the SECMs; in negotiating these differences, both groups of midwives highlighted moments of discomfort and insecurity in relation to their practice, thus demonstrating an interesting dichotomy in midwifery in Ireland that calls for further exploration.

9.4.4 Midwifery in Obstetric Spaces

Although some of the HMWs welcomed the SECMs, most were uncomfortable with their presence in the labour ward. Findings from interviews with the SECMs indicated that they felt judged by HMWs, while HMWs also felt that their practice was judged and challenged by SECMs. The HMWs suggested that the dynamic was difficult when the SECM remained after transfer, as the women continued to look to their SECM for guidance. They suggested that this placed them in an awkward position if, for example, the SECM did not support their decisions. Conflicts of

different understandings of birth were noted, and how the intra-professional boundaries were contested during experiences of in-labour transfer. The HMWs also felt that their ability to offer midwifery support was questioned and that women and SECMs did not consider them capable of facilitating normal birth. While HMWs maintained that their practice was guided by an understanding of normal birth, their perceptions of home birth and in-labour transfer cast some doubt on this claim. These midwives (as they acknowledged) have little practical exposure to birth outside the obstetric gaze. Therefore, I suggest, in keeping with the findings of O'Connell and Downe (2009) that their construction of normality is positioned within tight parameters where labour is timed and measured and interventions are at the ready. In this sense the HMWs in this study showed compliance with the cultural norms of hospital birth.

The HMWs' interpretations of in-labour transfer offered little or no challenge to the current provision of maternity care and the historical and cultural construction of birth in Ireland. Any suggestions they made for the future of maternity care lay in their belief that SECMs need to align their practice with hospital birth. The findings in this study indicate that the HMWs, for the most part, are active agents in the medicalisation of birth. Hyde and Roche-Reid (2004) noted ten years ago that HMWs in Ireland accepted the medical approach as a 'normal' aspect of birth. The present study suggests that they continue to do so, thus highlighting the paradox of midwifery in Ireland.

9.5 Obstetricians – Occupying a Confident Space

The findings of this study, as noted across participant groups, indicated clearly that the obstetricians remain the driving force behind birth in Ireland and the organisation of the maternity services. Despite small areas of resistance to the dominant discourse, the obstetric hegemony goes largely unchallenged and continues to shape the definition of normal birth and how birth should be best 'managed'.

9.5.1 At Home with Home Birth?

This study found that the obstetricians' descriptions of home birth and of in-labour transfer were framed, for the most part, in negative terms. This understanding of birth was embedded in the discourse of surveillance and risk. In most narratives, they highlighted their perceptions of the inherent risks of home birth and the factors that resulted in poor outcomes. They were not convinced about the safety of home birth, nor were they convinced of the safety of SECMs. Multiple references were made to the support and expertise in hospital considered necessary to safeguard against the uncertainty they associated with birth. The obstetricians admitted that their opinions were based mainly on their personal experiences and on anecdotal stories that circulated in conversations with colleagues. This echoes the findings of Cheyney et al (2014a) who found that the hospital-based providers, based on their personal experiences, believed that home birth is more dangerous than is reflected in the findings of current research studies. Cheyney et al's study took place against a backdrop of hostility to home birth (Cheyney 2011). This is borne out in documents such as the American Congress of Obstetrics & Gynecology's (ACOG 2011) position paper on planned home birth; while supporting women's autonomy, the ACOG statement does not encourage home birth. Published papers such as Chervenak et al (2013) and Chervenak et al (2011) question the ethical and scientific justification for planned home birth. Chervenak et al (2013, p. 185) go as far as stating that "... *attendance at planned home birth is a violation of professional responsibility*". Cheyney (2014b, p. 2) call this a "*crusade against home birth*" and suggest that it is not motivated by research or by "*concerns for women*". Cheyney and colleagues propose that such a view does little to develop or support safe childbirth. In Cheyney et al (2014b, p. 3), a "*European model of physician-midwife cooperation*" is held up as an example as against the more aggressive relationships described in the US. However, the sweeping assertion that all is perfect in Europe and that its model of cooperation should be aspired to is highly questionable. The organisation of maternity care varies from country to country; therefore "*a European model*" does not exist. Secondly, as noted in the findings of my study, home birth does not receive a *carte blanche* nor is it embraced by all members of the healthcare team in Ireland.

The obstetricians in my study did not directly say that they did not support home birth; in fact, they made several statements to indicate that they support women's choice. However, the narratives indicate that choices were supported only in so far as they remained within the obstetricians' framework of birth. While saying that they supported home birth, the obstetricians were resolute in stating that they were not comfortable with the current arrangement, and they called for urgent changes to the governance structures of home birth in Ireland. Their anecdotal reference to incidents from some time ago indicated that their knowledge of more recent data of home birth in Ireland and the operationalisation of the MOU is limited. This highlights the need for visible data relating to home birth in Ireland and publication of an annual report,¹⁶⁹ along with a realistic strategy to disseminate this information.

9.5.2 Skewed Perceptions of Transfer

The obstetricians' reading of risk underpinned all their discussions in relation to home birth and was displayed in their understanding of transfer. They stated that they were not involved with all transfers from home birth, but rather were consulted during an emergency or asked to intervene when women did not consent¹⁷⁰ to elements of care that HMWs or junior doctors deemed necessary. It must be acknowledged that these descriptions did not depict involvement with smooth transfers as described by the other participants of this study. The obstetricians highlighted that they had little contact with *successful* home births (some obstetricians in the USA admit that their lack of exposure leaves them fearing home birth (Wendland 2013)). I suggest that obstetricians in Ireland have little exposure to *successful* transfers and that this further influences their negative perceptions of home birth. Reminiscent of the findings concerning HMWs, obstetricians stated that they always assumed the worst when they were informed that a woman was transferring from home birth. Similar to the HMWs, they often based this on a previous experience or anecdotal hospital

¹⁶⁹ The HSE in 2013 published such a report: 'Planned Home Births in Ireland, 2012'. It is not known if this was just a once-off publication; there is nothing to suggest that an annual report is envisaged.

¹⁷⁰ See "informed compliance" in Section 9.4.2.

conversation. ‘Assuming the worst’ also emerges from Cheyney et al (2014a); one of the home birth midwives referred to such a biased preconceived notion as “*medicine-based evidence instead of evidence-based medicine*” (Cheyney et al 2014a, p. 450). The findings of my study add further evidence to the argument made by Davis-Floyd (2003) and Cheyney et al (2014a) that obstetricians frame all birth in terms of their cultural understanding of risk.

The obstetricians in this study questioned every aspect of SECMs’ practice (e.g. the appropriateness of women suggested suitable for home birth, decision-making in specific situations, the timing of transfer to hospital) and suggested that, in many cases, SECMs were working outside their “*scope of practice*”. The obstetricians also suggested that the SECMs continued to offer care at home when a different course of action or intervention was required. This was frequently cited as the reason obstetricians criticised SECMs’ practice. This contrasts sharply with the findings from interviews with the SECMs, who suggested that the current construction of the MOU and the HSE’s interpretation of guidelines as rules constrain and restrict their ability to provide autonomous midwifery practice. The SECMs believe that the current provisions of the Nurses & Midwives Act (Government of Ireland 2011) mean they have little choice but to follow the letter of the MOU even if they disagree with the guideline. The home-birth midwives in Davis-Floyd (2003) and Cheyney et al (2014a) were also charged with working outside their professional boundaries. In their jurisdictions they were accused of looking after “high-risk women” at home (Cheyney et al 2014a). This did not emerge in my study, but nonetheless the obstetricians’ voiced concerns related to the care offered by SECMs and some of the decisions they made.

9.5.3 Independent Midwives – Too Independent

The obstetricians in this study clearly expressed their assumption that SECMs consider themselves an independent entity and have the freedom to practise as they see fit.¹⁷¹ They suggested that structures governing SECM

¹⁷¹ This opinion contrasts greatly with that of the SECMs. All the SECM participants of this study were quick to stress that evidence underpins their practice. They identified

practice were either absent or not stringent enough. The MOU was dismissed as not doing enough to regulate and control their practice. Several references to historical cases (before the existence of the MOU) were made, and examples of the poor practice of “*independent midwives*” were cited. In these cases, the obstetricians believed that the independent midwives had not been appropriately regulated by their professional body. They proposed that the governance structures in place in maternity hospitals should be extended to include the supervision of SECMs within their remit. This, in their view, would serve to align SECMs and their practice with the policies and guidelines of local maternity hospitals. Obstetricians held this as a positive move, showing little regard for the critique of the current provision of care provided by maternity hospitals or the inappropriateness of hospital guidelines for normal, physiological birth. Both obstetricians and HMWs, proposed that SECMs should spend some time practising in maternity hospitals so that they could become acquainted with the “*hospital way of doing things*”. These findings indicate that obstetricians and HMWs in this study genuinely hold the belief that all midwifery practice should be in line with the model of care currently offered by maternity hospitals in Ireland. While exposure to the culture of hospital birth was not suggested by participants in Cheyney et al (2014a), it was suggested that home birth midwives “mis-managed” women’s labour. Hospital-based practitioners suggested that more education and a standardised route to certification¹⁷² were required. Echoing the findings in my study, the above suggestions called into question the midwives’ knowledge and skills, and indicated an assumption that hospitals and those who practise in them are the role model for all. I argue that this broad assumption is inappropriate and does not support the ongoing development of the maternity services. As suggested in previous sections of this discussion, such opinion in relation to *one model*

constraints in their ability to practise as autonomous midwives (as set down by the ICM), suggesting that interpretations of the MOU and the dominant discourse of obstetrics muted their voice and constrained their practice.

¹⁷² All SECMs in Ireland have achieved registration as a midwife with the Nursing & Midwifery Board of Ireland. Some midwives are ‘direct entry’; they are solely registered as midwives without nursing education. Others are midwives but qualified first as a nurse. There is a mixture of both ‘types’ of midwife in the maternity services in Ireland, with a higher number of direct-entry midwives working in hospitals than the community. I suggest two reasons for this: an undergraduate, four-year, direct-entry programme has only been available since September 2006; and, secondly, the MOU states that a midwife must be qualified for three years before signing an MOU.

as a template for all models will not meet the needs of all women and should not inform the provision of maternity care in Ireland.

9.5.4 Authoritative Knowledge and Cultural Power

In the interactions at transfer, the obstetricians demonstrated the position of power that they occupy within the structure of maternity care. Hospitals were held as their territory. This cultural construction of power was recognised by all participant groups in this study.¹⁷³ Obstetricians proposed that they were responsible for the wellbeing of women and their babies. They used phrases such as “*my responsibility*”, “*my jurisdiction*”, “*my case*” to denote their authoritative role in birth. This authority was maintained by the use of unconcealed threats when SECMs were told to “*back off, this is my jurisdiction*” during points of disagreement over care. These healthcare practitioners did not verbalise any signs of doubt in relation to their understanding of birth. While both groups of midwives admitted to feelings of vulnerability and uncertainty,¹⁷⁴ the obstetricians demonstrated their complete belief in their knowledge and practice. This cohort of obstetricians did not make reference to the fear of litigation that is noted in the American studies (e.g. Davis-Floyd 2003, Cheyney et al 2014a). Their statements and narratives evinced an unassailable confidence in their knowledge, skills and authority.

The findings that emerged from the interviews with obstetricians show how cultural constructions of power are evident in their interactions not only with SECMs but also with women at transfer. The obstetricians tended to assume that the decisions women made in relation to aspects of care would not be in keeping with their (the obstetricians’) perceptions of the “*safest management*”. In these situations, obstetricians perceived a dichotomy between desire and safety, suggesting that women’s plans for birth were not informed by realistic expectations. Kirkham et al (2002) and Frenndriksen (2005) noted that women in these circumstances may be seen as

¹⁷³ E.g. the obstetrician used the term “*my jurisdiction*”. HMWs noted that obstetricians were the “*lead healthcare professionals*”, in charge once transfer occurred. SECMs spoke of hospitals as ‘the world’ of obstetricians and medical birth. Women talked of having to “*do what I am told*” once they entered the hospital setting.

¹⁷⁴ SECMs and HMWs spoke at length of their professional practice being judged by other healthcare practitioners.

irresponsible, by rejecting the obstetric reading of risk. In this impasse lies the crux of the obstetricians' argument that women have rigid expectations about their birth, "*an unpredictable and inherently risky process*" (as stated by one of the obstetricians). It is not clear if these expectations were considered unrealistic because they did not adhere to the understanding of birth espoused by hospital practitioners, or if the women were considered to be unprepared for birth. (I suggested previously that primiparous women in this study were taken aback by some of the events of labour (Section 9.2.3); this issue may thus require further attention and exploration.)

In summary, the findings of this study indicate that a polarisation of views of birth prevails in the organisation and provision of maternity care in Ireland, and is played out in interactions at the interface of home and hospital birth. In Sections 9.6, I will theorise the key findings of this study and outline how it advances understanding of the interface of home and hospital birth and the debate on birth in Ireland. I attempt to break away from the dichotomy of the *home versus hospital* debate and find common ground on which to lay the foundations to develop the maternity services in Ireland.

9.6 Visiting and Revisiting Power, Risk and Trust

Chapter 2 referred to Robbie Davis-Floyd and her conceptualisations of interactions during transfer to hospital from planned home birth (Davis-Floyd 2003). Examples of Davis-Floyd's "articulations" are evident within the findings of this work. These articulations do not occur in a social vacuum; the findings from my research indicate that they are shaped by deeply held beliefs in relation to safety and risk, and issues concerning trust and the power/knowledge nexus that has maintained the medical dominance in the provision of the maternity services in Ireland. These concepts do not stand in isolation, but are inter-related. This discussion will now draw from the work of a number of writers (referred to in Chapters 4 and 5). Michel Foucault's theory of disciplinary power is used to explore the structures of knowledge/power evident in this study and how obstetric hegemony prevails in the current provision of maternity care in Ireland. The writings of Mary Douglas and Ulrich Beck on risk provide an understanding of the

cultural paradox of midwifery in Ireland and how this contributes to the construction and reconstruction of normal birth expressed in this study. I also draw on Anthony Giddens and Niklas Luhmann in relation to trust theories, and identify how trust and mistrust are established and maintained in interactions between the proponents of home and of hospital birth.

9.6.1 Structures of Power

The findings of this study indicate that, regardless of where women choose to birth or where midwives choose to practise, the traditional polarised understandings of birth and the dominance of obstetric discourse in contemporary maternity care featured strongly in their experiences. The opening chapters provided a social and cultural critique of the history of childbirth in Ireland, including the relocation of birth to hospital, the rise of obstetric medicine, and the ‘invisibility’ of midwifery in Ireland. The findings of my study indicate that, in spite of an abundance of research in relation to the safety of home birth (Olsen & Clausen 2012, Brocklehurst et al 2011, de Jonge et al 2013, Janssen et al 2009) and the benefits of midwife-led care for women experiencing a ‘low-risk’ pregnancy (Walsh & Devane 2012, Sandall et al 2013), home birth and midwifery remain contested sites in the culture of birth in Ireland.

Chapters 4 and 5 referred to Foucault and his theory of knowledge and its disciplinary regimes (e.g. hospitals) that render docile both public and individual bodies (Foucault 1980, p. 140). Foucault’s concept of genealogy has provided a useful lens to understand the operation of power at the interface between home and hospital birth, linking specific forms of knowledge with specific forms of social control. The obstetric discourse that lay successful claim to birthing power/knowledge during the 20th century continues strongly to influence maternity care in Ireland into the 21st century. This is evident not only in the moments of power highlighted throughout the findings of this study, but also in the structures in place to govern home birth (e.g. the MOU). Murphy-Lawless (1998) suggests that obstetricians lay claim to ‘truth’ and authoritative knowledge by virtue of their claim to science, using the obstetric discourses of risk and risk aversion, and the need for medical management of labour as a way to retain

control of birth. In spite of these assertions of knowledge, the obstetricians (and some midwives) in my study demonstrated that their perceptions of home birth and transfer were informed by hospital anecdotes and historical experiences. However, because of the cultural acceptance of the obstetric understanding of safety and risk (Fox 1999), obstetricians' sources of knowledge tend to be placed beyond critique. Even though the obstetricians in this study have not moved beyond old experiences as evidence, the culturally held belief that home birth is not safe remains firm, and was clearly evident in the negotiations at transfer.

Foucault (1977) proposes that dominant discourses are constantly creating and maintaining boundaries through the development of power and knowledge. Those operating within the discourses decide who has access to or is denied knowledge, and thus who maintains control, while subjugated discourses remain at the margins (Foucault 1980). In the present study, the obstetricians' efforts to maintain their authoritative position are clearly evident: in their interactions with both women¹⁷⁵ and with SECMs.¹⁷⁶ Strategies to maintain their position were also apparent in the recommendations they made for home birth, suggesting that it should occur within the governance structures of the hospital, and that SECMs should align their practice to the guidelines of hospital birth. The concept of the 'panopticon' and what Foucault calls 'the gaze' (continuous surveillance) (Foucault 1977) also helps to explain how obstetric power is maintained. Once the belief that you are being observed is internalised, Foucault suggests, you become your own observer, and thus become a 'docile' subject willing to comply with disciplinary power (Foucault 1977). Most of the HMWs in this study located their practice in the routines of medicalised birth. This was demonstrated in the way they spoke of birth, their conversations with pregnant women, and the way they anticipated transfer and reacted to SECMs. These midwives gave no indication that they

¹⁷⁵ Women were criticised for choosing home birth, told during pregnancy that what they were doing was dangerous for their baby; obstetricians maintained their rhetoric of hospital as the safest place for birth. During transfer the women spoke of not having a voice, of having to "do what I was told", and of little regard being given to personal choices.

¹⁷⁶ The professional practice of SECMs was judged; SECMs felt vulnerable that obstetricians would instigate disciplinary action if they did not agree with their practice.

challenged the organisation of care. Some midwives said that they were powerless to do so;¹⁷⁷ using the words of Davis and Walker (2010):

“... in the obstetric hospital setting where the constructions of medicine dominate, midwifery knowledge and practices are marginalised and this power dynamic shapes midwifery practice in this setting, in a particular way.”

(Davis & Walker, 2010, p. 380)

Their narratives (and some birth stories) indicate how midwives in Ireland reinforce the cultural norms of hospital birth and have reconstructed midwifery practice therein. Kirkham (2000) suggests that this organisational context of midwifery distracts from the fundamental aspects of midwifery practice (e.g. relationships with women) as midwives become more subsumed into the discourse of medicalised birth. This reconstruction is most evident at the interface of home and hospital birth and in the contested intra-professional struggles demonstrated therein (e.g. disagreements in relation to care, midwives feeling judged by other midwives, midwives not ‘allowing’ the SECMs to remain with the women).

The SECMs’ narratives reveal that they remain at the margins of maternity care and have to constantly negotiate their position within the organisation of the maternity services in Ireland. Foucault’s concept of genealogy examines the history of struggles between dominant and subjugated knowledge to provide a space from which the less dominant voice can be heard (Foucault 1973, 1977). The goal is “*to disrupt the taken-for-granted-present and show how things could be*” (Bunton & Peterson 1997, p. 3-4). Foucault’s analysis of power as weblike rather than linear (Foucault 1998) means that resistance is possible at every interaction during transfer; thus some level of disrupting of the obstetric hegemony is possible. The findings of this study have shown that the resistance of SECMs is subtle and covert. The midwives referenced historical and recent events that have called into question the professional credibility of SECMs and suggest that these have led them to this course of subtle resistance. This does little to challenge the balance of power within the maternity system; thus the status quo remains.

¹⁷⁷ I will return to this again when exploring how risk was perceived by the participants of this study.

The women follow a similar path of subtle resistance. Confrontational encounters with obstetricians during pregnancy and a fear of being denied their home birth underpin this approach. In their experiences of in-labour transfer, the women felt unable to question the powerful knowledge of obstetricians. They cited their belief that hospital was not their space, but rather the domain of obstetricians and hospital-based midwives. However, accepting that hospital is the domain of obstetricians and HMWs does not mean that the care there is beyond criticism. As noted in a previous chapter, one woman referred to “*powerful knowledge that means nothing*”. The women participating in this study did not feel that their voice had been heard in most of their interactions with obstetricians.

The findings of this study provide a critique of the current organisation of the maternity services in Ireland. This critique is located in women’s perceptions of the current provision of maternity care, and in the SECMs’ narratives and how they contrast their understanding of birth and care with the authoritative obstetric discourse. Home birth may provide an alternative to the cultural norm of hospital birth in Ireland; however, the findings in this study clearly indicate that medical dominance remains and is present even when an obstetrician is not.¹⁷⁸ The international literature holds home birth as a free space (Davis-Floyd 2003) in contrast to the controlled and controlling space of hospital birth. However, in the context of birth in Ireland this space is becoming governed by social constructions of risk (e.g. the MOU) and more tightly aligned to the prevailing perceptions of obstetric hegemony.

9.6.2 Blurring Safety and Risk

This study is not about the safety of home birth versus the safety of hospital birth, nor was it my intention at the start of this project to get ‘dragged into’ that debate (naivety on my part, I might add). However, the *home versus hospital* discussion, as demonstrated in the findings, laid the foundation for

¹⁷⁸ E.g. the lingering impact of antenatal encounters on women’s perceptions of transfer, the dread of transfer and judgement noted by SECMs, the ever-present MOU and obstetric rules therein.

interactions at transfer. Obstetricians in this study raised a culturally constructed question of the safety of home birth (it would be wrong to claim that they directly said they did not support home birth). Aside from the fact that no-one in Ireland had asked obstetricians about their views of home birth in the context of a study before, the finding that they were unsure about home birth echoes what the plethora of international literature has shown concerning obstetricians' views on birth at home (Lokugamage 2011). What is different in this context is the impact that this culturally constructed question has on home birth, on the provision of maternity care and on midwifery (in a country with a National Home Birth Service). The findings of this study illustrate many of the features of Beck's risk society, (Beck 1992) and Mary Douglas's writings on risk and otherness (Douglas 1992).

The movement of birth from home to hospital was explored in Chapter 3 alongside the cultural understandings that link safety to hospital and to medicalisation of birth. Chapters 3 and 4 explored how this became the norm in Ireland and how obstetrically managed birth has prevailed. Midwifery is frequently held in binary opposition to obstetric discourse and understandings of risk and safety (Murphy-Lawless 1998). However, this is not reflected in the findings of my study. The discourses of medical birth are upheld by HMWs (briefly mentioned in 9.4.2). Beck (1992) suggests that sensitivities to risk operate to influence contemporary life. The findings of my study indicate that sensitivity to risk has transgressed the boundaries that once separated obstetricians and midwives and is now part of midwifery practice. The HMWs held tight to the routines of medicalisation. When interacting with the SECMs, the majority judged any care not in keeping with hospital policies and guidelines grounded in the protocols of active management of labour as, at best, inappropriate and risky, and as, at worst, unsafe and dangerous. This understanding of risk is explained by Beck's Reflexive Modernisation (Beck 1992); the HMWs drew from the 'expert' (i.e. obstetricians) interpretation of risk. I am not suggesting that these HMWs have divorced themselves from the professional principles of midwifery (many were quick to point out that they "*can support normal birth too*"). However, it is reasonable to suggest that they construct normal

birth within the obstetric discourse of risk and surveillance, thus marginalising the understanding of birth as a normal physiological event. The literature to date in Ireland, which criticises the medicalisation of birth, has failed to capture the midwifery contribution to preserving the hegemony of obstetric discourse. Without losing sight of the power relations that affect midwives' agency, I think an exploration of this issue is warranted. Several reviews of the maternity services (as referenced in earlier chapters) have called for an urgent reconfiguration of the maternity services in Ireland to incorporate more models of midwife-led care. I add to this call. However, in light of the disconnect between the rhetoric of normal birth and practice of surveillance displayed by HMWs in this study, it is vital that we understand where midwives are positioned in relation to their understanding of normal birth and risk. Otherwise we are in danger of just transporting the institutional mechanisms of risk management to a different venue.

In contrast to hospital-based practitioners, SECMs seek to practice in a way that assumes normality rather than focusing on the possibility of pathology. However, as noted in the findings of this study, SECMs do not escape the influence of the obstetric perception of risk. The MOU and the threat of disciplinary action (lack of professional support) are held accountable for this, as SECMs honour the evidence as represented in the MOU even if it does not reflect their thinking. The construction of the MOU is clearly influenced by the risks that are privileged in the understanding of hospital birth. Douglas (1992) states that the cultural context in which risk is understood influences which risks are the focus of guidelines and protocols. In this sense it has been demonstrated that the SECMs are working to guidelines that are not in keeping with their understanding of birth. This provides another example of the dominant discourse maintaining its strong hold on birth in the current provision of maternity services in Ireland. I am not suggesting that the way forward is to cast aside all the evidence-based guidelines, nor was this proposed by any of the supporters of home birth who participated in this study. However, I am suggesting that the governance surrounding home birth in Ireland requires review. This must take equal account of all discourses, and not be dominated by the discourse of one specific group. This study aimed to give a voice to the non-dominant

discourse. However, Foucault (1991) cautions against replacing one dominant discourse with another, or holding the subjugated discourse as *the* truth, as if it is perfect. Issues of appropriate practice and guidelines for transfer certainly have a vital place in home birth and in supporting all involved. However, this cannot be informed solely by the routines of medicalised birth, nor can it be isolated from women's autonomy and the different understandings of birth.

9.6.3 Locating Trust

The findings have shown that the nexus between risk and trust as well as perceptions of power were significant for all the participants of this study. Trust, mistrust and distrust were evident in the women's narratives, which revealed where trust was located in their interactions and relationships with healthcare providers. The obstetricians and midwives also raised issues of trust; for the most part they focused on the trust or mistrust they placed on other healthcare providers, their confidence being underpinned by their judgements of the practice of others. I will focus first on aspects of trust in the women's narratives.

I have made considerable efforts in the findings chapters not to stray into my observations of home birth, for numerous reasons, including to ensure I stayed focused on the aims and objectives of the study, and to make certain that when I did venture there I would do so to draw comparisons that were useful to my understanding of transfer. At times I saw the need to just draw on the raw data and leave the words (of women who told of positive home birth stories) to paint an eloquent ethnographic picture that in itself does all the talking that is needed (See Chapter 8).¹⁷⁹

From the onset of this study, the women were very clear about their motives for choosing home birth. I have, in the findings chapters and in this discussion, explored these reasons in detail, noting their relevance to

¹⁷⁹ One example – "... it [the birth] was everything I dreamed of, that's exactly what I wrote I wanted without realising that I could have that She [SECM] was there, she was with me every step of the way, holding me in her strength, making me feel special, keeping me safe, I knew, and I knew that I could do it" (Eibhlin).

women's experiences of transfer to hospital. Many of the women chose to birth at home because they wanted a healthcare professional with them that they knew, someone who knew them, someone they trusted. Others wanted to avoid hospitals and a system that they did not believe necessary for normal pregnancy and birth. Trust, in these situations, was strongly associated with social and emotional safety, and ties in with the women's understanding of birth (risk)¹⁸⁰ and the women's sense of control (power).¹⁸¹ Hupcey et al's (2001) advanced concept analysis of trust helped me to make sense of these findings. Hupcey et al (2001, p. 290) note the preconditions of trust to include "*a need that cannot be met without the help of another*", and "*prior knowledge about the other*". All the women in this study chose home birth based on their needs (physical, psychological and emotional) in the context of their knowledge or prior experience of the maternity services and of healthcare professionals.

The women conceptualised trust in a number of ways to describe their relationships with their SECMs and their views in relation to home birth. In their narratives, trust was associated with a shared understanding of birth, shared personal experiences, a confidence in the SECMs' knowledge and skills, a sense of personalised care. Distrust and mistrust were evident in some women's narratives of hospital birth when interventions and care were held as routine and women felt they would have no voice. Giddens's (1994) and Luhmann's (1990) theories of trust, specifically institutional and interpersonal trust, provide useful insights into the women's narratives. Giddens's (1991) belief that trust acts as a medium of interaction between institutions/representatives of the institutions and outside individuals explains why confrontational interactions with obstetricians (during pregnancy) can affect and influence women's perceptions of hospital birth and their experiences should transfer occur. Luhmann (1988) argues the reverse in a sense, maintaining that trust in the system is necessary before an individual is trusted, thus contributing to the thesis that trust on both

¹⁸⁰ The women wanted to be supported by a healthcare professional they believed to hold the same understanding of birth. They talked of SECMs believing in normal birth, supporting normal birth and instigating transfer "*only when completely necessary*".

¹⁸¹ The women stated that they wanted a healthcare provider who would listen to them and include them in the decision-making process, not someone who would be bound to the routines of an institution.

levels needs to be addressed when determining how to enhance the interface of home and hospital birth.

There are some contradictions in the theories of trust originated by Giddens (1990) and Luhmann (1979). However, Meyer et al (2008) extend these theories, and state that trust is not linear but interactive within relationships and may originate at the institutional or the personal level. This is helpful when women assumed contradictory positions in their narratives.¹⁸² Meyer et al's (2008) proposition, when viewed in the context of the discourses of risk, goes some way to help understanding of my previous assertion that the women in this study located safety and trust in individuals while the hospital-based practitioners located safety and trust in the routines of institutions. Realising and acknowledging this is the first step to establishing *common ground* in moves away from the binary to a continuum of maternity care.

The interviews with the midwives and obstetricians in this study revealed varying levels of trust in their perceptions of and interactions with each other. It is difficult to discuss inter- and intra-professional trust in the context of this study without repeating the issues within power and risk explored in the previous sections. Trusting relationships were formed in the context of mutual respect, an acceptance of different understandings of birth and a desire to work with the needs of the women as the focus. Bridgette Jordan (1993) terms this cross-cultural collaboration "mutual accommodation". In Section 9.9 I propose recommendations that arise from the findings of this study that will work toward 'finding common ground'

9.7 Methodological Contributions

Developing a methodology of multi-sited ethnography enabled an exploration of the culturally embedded interface between home and hospital birth. Following birth across geographical and socio-cultural spaces of home and hospital allowed for deeper understanding of the power structures

¹⁸² E.g. they highlight that they trusted a particular midwife when they transferred to hospital even though they did not trust birth in hospital *per se*, or that they trusted an SECM even though she had not been their original choice of midwife.

and the connections and disconnections between the participants and the space they were in. In using this multi-sited method I was able to move my focus between the women, SECMs, HMWs and obstetricians, and therefore greater understanding of the complexities of the interface between home and hospital birth emerged. Undertaking an ethnographic study across home and hospital birth including women, midwives and obstetricians is unique to this study and therefore, I suggest, enhances the valuable contribution of this thesis to the debates around place of birth and models of maternity care.

A challenge faced by every ethnographic researcher emerged in the stages of write-up. My dilemma lay in my ability to capture the meanings and significance of what I heard and saw in the participants' experiences whilst acknowledging my role in shaping the text. Adapting VCRM as a framework helped me to overcome this challenge. Reading for the stories, as is inherent within the framework, allowed me to embrace the inter-subjectivity and multiple realities of the participants and to reflect on my subjectivity and my personal and professional assumptions. VCRM provided a useful guide not only for my exploration of the data but also for my representation of the ethnographic stories. As recommended by Mauthner and Doucet (1998), I focused on how the participants of this study spoke of themselves before I positioned their experiences in the wider socio-cultural context of birth. Using VCRM helped me to maintain the voice in the field (mine and that of the study participants) in my writing; thus the participants of this study are visible as active and critical producers in this thesis. I suggest this framework has merits for future ethnographic endeavours.

9.8 Limitations of the Study

In Chapter 6, in keeping with the self-reflexive methodology of critical ethnography, I acknowledged the features that both constrained and enhanced the study. As is the case with any scientific research, there are limitations to the current study that should be taken into account when drawing conclusions from the findings.

The findings present a vivid account of the interface between home and hospital birth at a particular time and crucial juncture in the history of birth in Ireland. While the study did not aim for quantitative generalisability, it is important nonetheless to acknowledge that the findings are culturally located. This study has sought to understand the stories of women, midwives and obstetricians. It could be argued that the participants of this study have a vested interest in presenting themselves in a way that shows them in the best possible light. The women and healthcare professionals were interested enough to give up their time in order to contribute to this study; some of them allowed me to observe an extremely personal aspect of their lives. Therefore, it could also be argued that the sample was skewed towards those who had particular views about home birth and perhaps had an agenda to expound. The voices of those who did not volunteer remain unheard and they may have had very different experiences. The relatively small sample size of some of the participant groups must be acknowledged (in particular the obstetricians) as well as the specific geographical setting in which observation of in-labour transfer occurred. While explanations are offered in relation to these points in Chapter 6, they must be recognised as limitations of this study. However, the methodology enabled an in-depth inquiry and, therefore, the findings may be transferable to women and healthcare practitioners in other jurisdictions and may guide the development of future research.

Due to my inability to predict which women would experience an in-labour transfer and those who would have a home birth (and which home birth I would get to observe), the data collection with all groups of women occurred concurrently. Data collection continued after I considered that saturation of conceptual themes had occurred. I felt it unethical to discontinue a woman from the study just because my subjective interpretation suggested that theoretical saturation had been reached.

In Chapter 6 I discuss the issues within participant observations that made it impossible, in my opinion, to audio-record the conversations. In these situations I was reliant on my ability to write discrete notes while observing, and write-up comprehensive fieldnotes after the event. While I kept my

fieldnotes as contemporaneous as possible, I acknowledge the limitations of this method.

My experiences as a mother, as a midwife and as a lecturer proved both enabling and constraining (I have referred to this in Chapter 6). Familiarity with birth meant access to the research site and to participants (I have, in Chapter 6 addressed my ethical concerns in relation to coercion). While this no doubt contributed to my '*getting in*' and '*fitting in*', it also meant that some of my decisions were located in my knowledge of the culture of birth in Ireland (e.g. where I physically positioned myself in the labour ward after transfer). Familiarity with midwifery and with the culture of birth may have made it initially difficult for me to focus on cultural distinctions within the interactions and experiences. It took me a short time in the field before I identified aspects of culture I had been immune to.

9.9 Recommendations – Finding Common Ground

This study has looked at deeply rooted social and cultural constructions of birth in Ireland. Immediate solutions that rid the culture of birth in Ireland of the dichotomy between home and hospital are not realistic; to suggest this would be to risk failing and thus to maintaining the professional silos evident in this study. I acknowledge the need to reconfigure the maternity services to include more models of care, as noted by several recent reviews of the maternity service (Brenner 2003, HSE 2005, Institute of Obstetricians and Gynaecologists 2006, KPMG 2008). The recommendations of my study add to, rather than repeat or challenge, the calls for change and the need for integration of services, as is evident in these reports. To these calls I add my voice and argue that a sustainable model supporting home birth is required; that options outside the dominant model of obstetric care must be made available, and that continuity of carer must be incorporated into and across the framework of all models in the provision of maternity care in Ireland. The recommendations of this study also offer proposals for more immediate changes to the provision of health policy, maternity services and ongoing professional and intra-professional education.

1) Health Policy

Findings from this study indicate that healthcare professionals do not consider the current structures governing home birth in Ireland to be appropriate. Obstetricians do not think them stringent enough; SECMs think they stifle their ability to provide individualised care in keeping with the role of the midwife, and do not address all their issues and concerns in practice. While recent revisions to national policy have occurred (e.g. the MOU), SECMs state that they were not fully part of the consultation process¹⁸³ while the obstetricians in this study seem to be unaware of their revision.

It is recommended that:

- guideline development in relation to the Home Birth Service (HSE) be continued and include an appropriate representation of all key stakeholders and a plan for dissemination to all those centrally involved;
- an urgent review of professional guidance for SECMs be carried out in relation to supporting women who no longer meet the criteria of the MOU and do not wish to transfer to hospital care;
- a framework be developed to assess women's needs in relation to home birth on an individual basis (intra-professional assessment);
- strategies be developed within the current operationalisation of the MOU to negotiate unique pathways of care (e.g. a combination of models) to specifically meet women's needs if they do not meet the current criteria for a home birth.¹⁸⁴

¹⁸³ While a new MOU was implemented with effect from March 2014, the SECMs (personal communication with SECM participants of this study in summer 2014) still feel that it does not offer appropriate support in certain areas of practice. They also suggest that it does not leave any room for intra-professional consultations and formulating pathways of care to meet the specific needs of women who fall outside the criteria.

¹⁸⁴ E.g. antenatal and postnatal care at home with the SECM, transfer to hospital for labour and birth.

The most disabling influence to emerge from the interviews with hospital-based practitioners stemmed from the historical basis of some of their anecdotal narratives, showing little insight into the current provision of home birth in Ireland.

It is recommended that:

- the HSE compile and launch an Annual Report of Home Birth in Ireland¹⁸⁵ so that more recent and accessible data are available to all healthcare providers

2) Maternity Services

The most significant problem, identified by the women and SECMs in this study, is the lack of continuity of care and of carer once a woman transfers to or engages with hospital birth. No formal agreement exists between hospitals and SECMs. Women were unsure if hospital staff would ‘allow’ their SECM to stay with them and continue to support them, or if they would be in a position to continue to offer care.

It is recommended that:

- an integrated care pathway be developed to include SECMs in antenatal consultations with hospital practitioners (when consultations are considered routine, in keeping with the MOU schedule, and when referrals to obstetricians are made);
- an integrated care pathway be developed to support SECMs to transfer with women to hospital.

Not being able to predict who they will meet on transfer emerged as a huge concern for SECMs and for women in this study. SECMs seek out hospitals and staff that they know are supportive of home birth. This was a concern for women and affected their expectations about their interactions in

¹⁸⁵ Similar to the one published by Meaney et al (2013).

hospital. Throughout this study, women showed that they placed their trust in individuals rather than the 'unknown' of the institution.

It is recommended that:

- each hospital identifies a named obstetrician as the point of referral and consultation(s) for women planning home birth and for SECMs;
- each hospital identifies a link midwifery team¹⁸⁶ or link midwives to liaise between women planning a home birth, SECMs and the hospital services.

Liaison must be facilitated during pregnancy and not just at the intense point of transfer during labour. Having 'known' persons identified gives women and healthcare practitioners alike the chance to get to know each other and therefore develop collaborative relationships.

The HMWs in this study showed discomfort with home birth and a reliance on the routines of medicalised birth. While reorganisation of the maternity services to include more midwife-led, woman-focused models of care is a long-term goal, some short-term strategies are also required.

It is recommended that:

- the current fragmentation of midwifery care be urgently reviewed; where possible midwifery teams and midwife-led options for care should be established within the current structures;
- where fragmentation of care continues, midwives rotate to all areas of the maternity hospital to ensure their exposure to all aspects of midwifery care;¹⁸⁷

¹⁸⁶ This may not be possible in all areas given the current fragmented organisation of care.

¹⁸⁷ The majority of HMWs who expressed fear in relation to home birth were allocated to an antenatal clinic.

- an urgent review of midwifery / hospital customs be carried out to explore practice based on tradition (e.g. not eating in labour, one support person only) and care that is evidence-based.

3) Education

The findings of this study indicate that focused and ongoing education is necessary across the groups.

It is recommended that:

- ongoing education supports be put in place for SECMs who wish to provide care to women after they transfer to hospital;¹⁸⁸
- SECMs continue to attend the Emergency Skills Courses (and other relevant courses) with hospital-based staff, and that transfer scenarios be included in these programmes;
- Normal Birth Workshops be provided across all maternity hospitals, and that HMWs and SECMs facilitate and attend these together;
- HMWs within the HSE commence an exchange/buddy programme with midwives in different jurisdictions, working within models of midwife-led care.¹⁸⁹

This study has attempted to break away from the dichotomy of the *home versus hospital* debate and find common ground on which to lay the foundations to develop the maternity services in Ireland. This study demonstrates that any attempts to bring closer the different understandings of home and hospital largely involve a unilateral process instigated by SECMs. All the supports listed so far in these recommendations may go some of the way to ensuring that midwifery care is a choice for all women

¹⁸⁸ E.g. a woman may decide she wants an epidural when she transfers to hospital; an SECM may need specific education and support concerning supporting a woman with an epidural.

¹⁸⁹ The findings of this study make clear some of the challenges for HMWs. Many are expected to practise midwife-led care without exposure to birth outside the confines of obstetric care.

in Ireland and that midwives are prepared for respectful interactions with obstetricians on an intra-professional level. In the lead-up to that, it is necessary to develop strategies for ongoing intra-professional development of SECMS and hospital-based staff, with a focus away from shared education in relation to obstetric emergencies and caesarean section rates, and instead a focus on equally important aspects of maternity care such as communication, cultural competency and collaboration.

4) Future Research

This study has indicated the need for further research in a number of areas, including:

- an assessment of the needs of midwives in changing healthcare services (what education assistance do midwives need to support them in the development of midwife-led services?);
- an exploration of why women, in Ireland, do not believe that HMWs can support normal birth;
- an exploration of women's experiences of labour and birth – why were elements of their labour considered unexpected?
- the question of how SECMS can move fluidly between the two models of maternity care so as to best fulfill their role as a home birth midwife?

9.10 Concluding Summary

This ethnography tells the story of a research study that explored the interface between home and hospital birth in Ireland. It presented and discussed the narratives and experiences of those centrally involved in in-labour transfer. The ethnography is not only influenced by the stories of the participants but also by my own experiences and by the broader socio-cultural discourses that influence birth in Ireland. As noted, the findings are specific to this study, but the new narratives generated therein can contribute to the dialogue informing midwifery practice and maternity care,

and influence the future provision of models of maternity care in Ireland. The study also reveals areas for future research.

This study indicates the extent to which place of birth, in 21st century Ireland, is still a contested issue. The politics of birth dominated by risk discourses led to debates over place of birth, protocol and procedures guiding care. The early chapters explored how discourses of risk and medical domination shifted birth to hospital, as well as the strategies employed to keep birth there. The findings of this study show how these discourses continue to influence maternity care into the 21st century and are exemplified during transfer from home to hospital.

Advocates of home birth construct and promote critical alternatives to the current cultural version of birth in Ireland. For the participants of this study, this is a deeply personal issue, and it is also considered highly political. Yet the findings illustrate that the authoritative knowledge of hospital birth (especially of obstetricians), fuelled by discourses of risk, remains the powerful dominant discourse at the interface between home and hospital birth. The stories I heard and observed tell of the various strategic manoeuvres whereby women and SECMs attempt to negotiate this dominant discourse, and yet the status quo remains. This study has brought into focus how the current maternity service (on both a micro and macro level) continues to apply the dominant discourse of obstetric readings of risk in the provision of maternity care. It has highlighted the impact that this has on women's experiences, including the issue of trust. Arising from the findings, the recommendations made are intended to serve as counterpoint¹⁹⁰ to the current dichotomy of birth in Ireland and help all concerned to find common ground.

¹⁹⁰ I borrow this word from music theory – “counterpoint requires two qualities: (1) a meaningful or harmonious relationship between the lines (a “vertical” consideration—*i.e.*, dealing with harmony) and (2) some degree of independence or individuality within the lines themselves (a “horizontal” consideration, dealing with melody)” <http://www.britannica.com/EBchecked/topic/140313/counterpoint>.

9.11 Final Comment ... For Now

During the final stages of writing this ethnography, an acquaintance, with an eye for critique but not associated with birth in any sense, set me a question -

“Linda, I’m wondering how far your findings and conclusions might be communicated, beyond the academic sphere, in the public arena? This is so important, not just for home birth women, but for all women giving birth in hospital, is it not”?

My reply –

“I am a midwife; I will always be a midwife. I cannot divorce that part of my being; therefore, whatever I do needs to make a difference to women’s lives”.

So here I am, back at the point I started from yet not back to where I started. I hope this ethnography and the thesis therein makes a difference to women’s lives.

“... when birth is done differently, it can help us develop an ethical stance that questions this unsustainable, exclusive and inhumane model [of maternity care] and starts to revalue connection – connection between mind and body, mother and baby, within families, between woman and midwife, between family and community and between disparate communities sharing similar struggles to make life more humane”

Nadine Edwards (2010), 109 – 110.

To conclude *doing birth differently* is not without challenge. Finding a common ground, as suggested in this thesis, will require the ongoing input and commitment of all voices of birth in Ireland.

References

- Agar, M. (1985) *Speaking of Ethnography*. Sage Publications Ltd: London
- AIMS Ireland (2013) AIMS Ireland response to the Home versus Hospital Birth Debate. 17th September, <http://aimsireland.ie/aims-ireland-response-to-the-home-versus-hospital-birth-debate/>. (Accessed February 2015)
- Allen, D. (2004) Ethnomethodological insights into insider-outsider Relationships in Nursing Ethnographies of Healthcare Settings. *Nursing Inquiry*, 11 (1), 14 -24
- Alvesson, M., Sköldbberg, K. (2009) *Reflexive Methodology, New Vistas for Qualitative Research*, 2nd edition. Sage Publication Ltd: London
- Amelink-Verburg, M.P., Verloove-Vanhorick, S.P., Hakkenberg, R.M.A, Veldhuijzen, I.M.E., Bennebroek Gravenhorst, J., Buitendijk, S.E. (2008) Evaluation of 280,000 cases in Dutch Midwifery Practices: a descriptive study. *BJOG: An International Journal of Obstetrics and Gynaecology*, 115 (5), 570–578
- American Congress of Obstetrics & Gynaecology (ACOG) (2011) Committee Opinion No. 476 Committee on Obstetric Practice Planned Home Birth. *Obstetrics Gynaecology*, 117 (2, part 1), 425 – 428
- An Bord Altranais (2000) *The Code of Professional Conduct for each Nurse and Midwife*. An Bord Altranais: Dublin
- An Bord Altranais (2007) *The Guidance to Nurses and Midwives Regarding Ethical Conduct of Nursing and Midwifery Research*. An Bord Altranais: Dublin
- Annandale, E., Clark, J. (1996) What is Gender? Feminist Theory and the Sociology of Human Reproduction. *Sociology of Health and Illness*, 18, 17-44
- Arney, W.R. (1982) *Power and the Profession of Obstetrics*. University of Chicago Press: Chicago
- Atkinson, P. (1992) *Understanding Ethnographic Texts*. Sage Publications Ltd: London
- Baszanger, I., Dodier, N. (1997) *Ethnography: Relating the Part to the Whole*, In: Silverman, D. (ed) *Qualitative Research: Theory, Method and Practice*. Sage Publication Ltd: London (p. 9 -34)
- Beck, U. (1992) *Risk Society: Towards a New Modernity*. Sage Publications Ltd: London
- Beck, U. (1999) *World Risk Society*. Polity Press: Cambridge.

- Beddall, H., Carr, M. (2010). Towards Normality: A Vision for Supervision. *Midwives: The Official Magazine of the RCM*. (September), 34–36
- Beech, B. (2009a) Midwifery: Running down the Drain. *AIMS Journal*, 21(3), 5
- Beech, B. (2009b) The Problems of Getting a Home Birth. *AIMS Journal*, 21(3), 7
- Begley, C., Devane, D., Clarke, M. (2009) An Evaluation of Midwifery-led Care in the Health Services Executive North Eastern Area. The Report of the MidU Study HSE: Dublin
- Begley, C., Devane, D., Clarke, M., McCann, C., Hughes, P., Reilly, M., Maguire, R., Higgins, S., Finan, A., Gormally, S., Doyle, M. (2011). Comparison of Midwife-led and Consultant-led Care of Healthy Women at Low Risk of Childbirth Complications in the Republic of Ireland: a randomised trial. *BMC Pregnancy Childbirth* 11 (Article number 85)
- Berger, P., Luckmann, T. (1966) *The Social Construction of Reality: A Treatise in the Sociology of Knowledge*. Double Day: Garden City, New York
- Biesty, L. (2012) The best Laid Plans of Women and Midwives. *The Practising Midwife*, 15 (3), 45
- Boucher, D., Benett, C., McFarlin, B., Freeze, R. (2009) Staying Home to give Birth: why women in the United States choose home birth. *Journal of Midwifery Women's Health* 4, 119 – 126
- Bray, A. (2014) Expectant mothers march in support of home birth midwife. *The Irish Independent*, 9th October, <http://www.independent.ie/life/family/mothers-babies/expectant-mothers-march-in-support-of-homebirth-midwife-30650481.html>
- Brenner H. (2003) Independent review of the Pilot Domiciliary Projects to the Domiciliary Birth Group ERHA: Dublin (unpublished)
- Brick, A., Layte, R. (2011) Exploring Trends in the Rate of Caesarean Section in Ireland 1999 – 2007. *The Economic and Social Review*, 42 (4), 383 - 406
- Brink, P.J., Edgecombe, N. (2003) What is becoming of Ethnography? *Qualitative Health Research*, 13 (7), 1028 – 1030
- Brocklehurst, P., Hardy, P., Hollowell, J., Linsell, L., Macfarlane, A., Mccourt, C., Marlow, N., Miller, A., Newburn, M., Petrou, S., Puddicombe, D., Redshaw, M., Rowe, R., Sandall, J., Silverton, L., Stewart, M. (2011) Perinatal and Maternal Outcomes by Planned Place of Birth for Healthy Women with low risk Pregnancies: the Birthplace in England national prospective cohort study. *British Medical Journal*, 343:d400.

- Brooks, F., Lomax, H. (2000) *Labouring Bodies: Mothers and Maternity policy*, In: Ellis, K., Dean, H. (eds) *Social Policy and the Body*. Macmillan Press Ltd: Hampshire
- Brown, L.M., Gilligan, C. (1992) *Meeting at the Crossroads: Women's psychology and girls development*. Harvard University Press: Cambridge MA
- Browne, A. (1995) *Masters, Midwives and Ladies-in-waiting: the Rotunda Hospital 1745-1995*. Farmar and Farmar: Dublin
- Browne, N. (1986) *Against the Tide* Dublin, Gill and Macmillan: Dublin
- Bunton, R., Peterson, A. (1997) Foucault's Medicine. In Bunton, R., Peterson, A. (eds) *Foucault, Health and Medicine*. Routledge: London (p. 1 -15)
- Burgess, R. (1984) *In the Field: An Introduction to Field Research*. Allen & Unwin: London
- Burns, E., Fenwick, J., Schmied, V., Sheehan, A. (2012) Reflexivity in Midwifery Research: The insider/outsider debate. *Midwifery*, 28 (1), 52 – 60
- Capp, B. (2003) *When Gossips Meet: Women, family and Neighbourhood in Early Modern England*. Oxford University Press: Oxford
- Carolan, M. (2003) Boards have no home birth obligations. *The Irish Times*, 6th November, <http://www.ireland.com/newspaper/ireland/2003/1106/2254645063HM3CTHOMEBIRTH.html>
- Carroll, M., Begley, C.M. (2003) *Diploma in Midwifery (Direct Entry) A Pilot Programme Midwife Registration Education Programme Final Report of the Evaluation*. School of Nursing and Midwifery Studies: Trinity College Dublin with The Rotunda Hospital and Our Lady of Lourdes, Drogheda
- Carspecken, P. F. (1996) *Critical Ethnography in Educational Research*. Routledge: London
- Catling, C., Dahlen, H., Homer, C. (2014) The Influences on Women who Choose Publicly-funded Home Birth in Australia *Midwifery* 30, 892 – 898
- Catling-Paull, C., Dahlen, H., Homer, C.S.E. (2011) Publically Funded Home Birth in Australia: A review of maternal and neonatal outcomes over six years. *The Medical Journal of Australia*, 198, 616 – 620
- Chadwick, R.J., Foster, D. (2014) Negotiating Risky Bodies: childbirth and constructions of risk. *Health, Risk & Society*, 16 (1), 68 - 83

- Chalk, D.L. (2009) *Managing Midwives in Early Modern English literature*. Unpublished Doctoral Dissertation: The Pennsylvania State University
- Chamberlain, G. (2006) British Maternal Mortality in the 19th and early 20th centuries. *Journal of the Royal Society of Medicine*, 99 (1), 559 - 563
- Chervenak, F.A., McCullough, L.B., Brent, R.L. (2011) Planned Home Birth: The professional responsibility response. *American Journal of Obstetrics and Gynaecology*, 205(4), 315, e1 – e5
- Chervenak, F.A., McCullough, L.B., Grunebaum, A., Arabin, B., Levene, M.I., Brent, R.L. (2013) Planned Home Birth in the United States and Professionalism: A critical assessment. *The Journal of Clinical Ethics*, 24(3), 184 -191
- Cheyney, M. (2008) Home Birth as a Systems-challenging Praxis: Knowledge, Power and Intimacy in the Birthplace. *Qualitative Health Research* 18(2), 245 – 267
- Cheyney, M. (2011) *Born at Home, the Biological. Cultural and Political Dimensions of Maternity Care in the United States*. Wadsworth Cengage Learning: USA
- Cheyney, M., Burcher, P., Vedam, S. (2014b) A Crusade Against Home Birth. *BIRTH* 41(1), 1 -4
- Cheyney, M., Everson, C., Burcher, P. (2014a) Homebirth Transfers in the United States: Narratives of Risk, Fear and Mutual Accommodation. *Qualitative Health Research*, 24 (4), 443 -456
- Christiaens, W., Gouwy, A., Bracke, P. (2007) Does Referral from Home to Hospital affect Satisfaction with Childbirth? A cross-national comparison *BMS Health Services Research* 7, 109
- Comhairle na nOspidéal (1976) *Discussion Document on the Development of the Maternity Services Comhairle na nOspidéal: Dublin*
- Condell, S., Begley, C. (2012) Clinical Research Ethics in Irish health Care: Diversity, Dynamism and Medicalisation. *Nursing Ethics*, 19 (6), 810 - 818
- Condon, D. (2000) *Report of the Review Group on Maternity Services in the North Eastern Health Board*. North Eastern Health Board: Kells
- Costigan L (2005) *Women and Healing*. iUbuverse: Lincoln NE
- Coxon, K., Scamell, M., Alaszewski, A. (2012) Risk, Pregnancy and Childbirth: What do we currently know and what do we need to know? An editorial. *Health, Risk & Society*, 14 (6), 503 -510

- Creasy, J.M. (1997) Women's Experiences of Transfer from Community-based to Consultant-based Maternity Care. *Midwifery*, 13 (1), 32-39
- Creswell, J.W. (2012) *Qualitative Inquiry and Research Design: Choosing among five approaches*, 3rd edition. Sage Publications Ltd: London
- Crotty M. (1998) *The Foundations of Social Research. Meaning and Perspectives in the Research Process* Sage Publications Ltd: London
- Crowley-Henry, M. (2009) *Ethnography: Visions & Versions*, In: Hogan, J., Dolan, P., Donnelly, P. (eds) *Approaches to Qualitative Research – Theory & its Practical Application: A Guide for Dissertation Students*. Oak Tree Press: Cork (p. 261-282)
- Cuidiú. (2011) Consumer Guide to the Maternity Services available in Ireland available at www.cuidiu.ict.ie
- Cullen, C. (2015) Home birth midwife Philomena Canning reinstated by HSE. *The Irish Times*, 26th February, <http://www.irishtimes.com/news/health/home-birth-midwife-philomena-canning-reinstated-by-hse-1.2118478>
- Daellenbach, R., Edwards, N. (2011) How can Birth Activism Contribute to Sustaining Change for Better Birthing for Women, Families and Societies in the New Millennium? In Davies, L., Daellenback, R. Kenington, M. (eds) *Sustainability, Midwifery and Birth*. Routledge, Taylor Francis Group: London. (p. 207 – 217)
- Dahl, C. (2001) Attaining Legitimacy: Eighteenth-century Man-midwives and the Rhetoric of their Texts. <http://grad.usask.ca/gateway/archive3.htm>. Accessed 14th May 2014
- Dahlen, H. (2014) Managing Risk or Facilitating Safety? *International Journal of Childbirth*, 4 (2), 66
- Dahlen, H., Barclay, L., Homer, C. (2010a) The Novice Birthing: Theorising First-time Mothers' Experiences of Birth at Home and in Hospital in Australia. *Midwifery* 26, 53–63
- Dahlen, H., Barclay, L., Homer, C. (2010b) 'Reacting to the Unknown': experiencing the first birth at home or in hospital in Australia. *Midwifery* 26, 415 – 423
- Dahlen, H.G., Barclay, L.M, Homer, C.S.E. (2010c) Processing the First Birth: Journeying into 'Motherland'. *Journal of Clinical Nursing* 19(3), 1977-1985
- Daly, D., OBoyle, C. (2010) Time to make midwifery matter in Ireland, *The Practising Midwife*, 13 (2), 15 – 17
- Davies, C.A. (2008) *Reflexive Ethnography: A Guide to Researching Selves and Others*, 2nd edition. Routledge: London

- Davies, S. (2009) A Jury of your peers? *AIMS Journal*, 21(3), 9-10
- Davis, D. and Walker, K. (2010) The Corporeal, the Social and Space/Place: exploring intersections from a midwifery perspective in New Zealand. *Gender, Place and Culture: A Journal of Feminist Geography*, 17(3), 377 – 391
- Davies, H., Wells, F., Czarkowski, M. (2009) Standards for Research Ethics Committees: Purpose, Problems and the Possibilities of other Approaches. *Journal of Medical Ethics*, 35, 382 – 383
- Davis-Floyd, R. (1992) *Birth as an American rite of Passage*. University of California Press: Berkeley
- Davis-Floyd, R. (1994) The Technocratic Body: American childbirth as Cultural Expression. *Social Science and Medicine*, 38 (8), 1125-1140
- Davis-Floyd, R. (2003) Homebirth Experience in the US and Mexico – the trouble with transport *Social Science and Medicine* 56 (9), 1191-1931
- Davis-Floyd, R. (2005) Daughters of Time: the post-modern midwife. *MIDIRS Midwifery Digest* 15 (1), 32-39
- Davis-Floyd, R. (2006) Introduction In: Davis-Floyd, R., Barclay, L., Daviss, B.A., Tritten, J. (eds) *Birth Models that work*. University of California Press: California (p. 1 -27)
- Davis-Floyd, R., Cheyney, M. (2009) Birth and the Big Bad Wolf: An evolutionary perspective. In Selin, H., Stone, P.K. (eds) *Childbirth across cultures: Ideas and practices of pregnancy, childbirth and the postpartum*. Springer Publishers: Dordrecht, The Netherlands. (p. 22)
- de Jonge, A., Mesman, J.A.J.M., Maanniën, J., Zwart, J.J., van Dillen, J., van Roosmalen, J. (2013) Severe Adverse Maternal Outcomes Among low risk Women with Planned Home versus Hospital Birth in the Netherlands: Nationwide cohort study. *British Medical Journal*, 346, f3263
- Delaney, L. McGovern, M., Smith, P. (2011) From Angela's Ashes to the Celtic Tiger: Early life conditions and adult health in Ireland. *Journal of Health Economics*, 30 (1), 1 -10
- Denzin N.K., Lincoln, Y.S. (2011) *The Sage Handbook of Qualitative Research*. Sage Publications Ltd: London
- Denzin, N.K. (2001) *Interpretive Interactionism*, 2nd edition. Sage Publications Ltd: London
- Department of Health and Children (1997). *The Report of the Maternity and Infant Care Scheme* (1994)

- Department of Health, UK. (1993) *Changing Childbirth Part I: Report of The Expert Maternity Group (Chair Lady Cumberlege)*. HMSO: London
- Devane, D. (2011) *Comparison of midwife-led and consultant-led care of healthy women at low risk of childbirth complications in the Republic of Ireland: a randomised trial (the MidU Study)*. Unpublished Doctoral Dissertation, Trinity College Dublin: Dublin
- Devane, D., Begley, C. (2004) *Childbirth: how Safe is Safe Enough*. *British Journal of Midwifery*, 12 (7), 416 – 417
- Devane, D., Murphy-Lawless, J., Begley, C.M. (2007) *Childbirth Policies and Practices in Ireland and the Journey Towards Midwifery-led Care*. *Midwifery*, 23 (1), 92-101
- deVries, R.G., Paruchuri, Y., Lorenz, K., Vedam, S. (2013) *Moral Science: Ethical argument and the Production of Knowledge about the Place of Birth*. *The Journal of Clinical Ethics*, 24 (3), 225 -238
- Dixon, A. (2013) *Challenges in Communication: Self Employed Community Midwives and Hospitals*. *Homebirth – Back to the Future*, National Maternity Hospital Conference: Dublin, 25th November
- Domiciliary Birth Group (2004) *Report to the Chief Executive Officers of the Health Boards Domiciliary Birth Group: Dublin (unpublished)*.
- Donnison, J. (1977) *Midwives and Medical Men: A history of inter-professional rivalries and women's rights* Heinemann Education: London
- Donnison, J. (1988) *Midwives and Medical Men: A history of the struggle for the control of childbirth*, 2nd edition. Historical Publications: London
- Douglas, M. (1992) *Risk and Blame. Essays in Cultural Theory*. Routledge: Oxon
- Downe, S. (2010) *Towards Salutogenic Birth in the 21st Century*, In: Walsh, D., Downe, S. (eds) *Essential midwifery practice: Intrapartum Care*. Wiley-Blackwell: Chichester (p. 289 – 296)
- Downe, S., Dykes, F. (2009) *Counting Time in Pregnancy and Labour*, In: McCourt, C. (ed) *Childbirth, Midwifery and Concepts of Time*. Berghahn Books: Oxford (p.61 -83)
- Downe, S., McCourt, C. (2008) *From Begin to Becoming*, In: Downe, S. (ed) *Normal Childbirth, evidence and debate*, 2nd edition. Churchill Livingstone: Oxford (p. 3 – 28)
- Drife, J. (2002) *The Start of Life: A history of obstetrics*. *Post Graduate Medical Journal*, 78, 311 – 315

Druml, C., Wolzt, M., Pleiner, J., Singer, E.A. (2009) Research Ethics Committees in Europe: Trials and tribulations. *Intensive Care Medicine*, 35 (9), 1636 – 1640

Dykes, F. (2004) *Feeling the Pressure – Coping with Chaos. Breastfeeding at the end of the medical production line.* Unpublished Doctoral Dissertation, University of Sheffield

Economic and Social Research Institute (ESRI) (2013) *Perinatal Statistics Report 2012.* ESRI: Dublin

Edwards, N. (2001) *Women's Experiences of Planning a Homebirth in Scotland. Birthing Autonomy.* Unpublished Doctoral Dissertation, University of Sheffield

Edwards, N. (2005) *Birthing Autonomy: Women's experiences of planning home births.* Routledge: London

Edwards, N. (2010) 'There's so much potential ... and for whatever reason it's not being realized'. – *Women's Relationships with Midwives as a Negotiation of Ideology and Practice*, In: Kirkham, M. (ed) *The Midwife-Mother Relationship 2nd edition.* Palgrave Macmillan: Hampshire (p. 91 – 115)

Edwards, N., Murphy-Lawless, J. (2006) *The instability of risk: Women's perspective on risk and safety in birth.* In: Symon, A. (ed) *Risk and Choice in Maternity Care. An International Perspective.* Churchill Livingstone, Elsevier: Edinburgh (p.35 – 49)

Edwards, N., Murphy-Lawless, J., Kirkham, M., Davies, S. (2011) *Attacks on Midwives, Attacks on Women's Choices.* *AIMS Journal*, 23(3), 3-7

Edwards, R., Mauthner, M. (2002) *Ethics and Feminist Research: Theory and practice*, In: Mauthner, M., Birch, M., Jessop, J., Miller, T. (eds) *Ethics in Qualitative Research.* Sage Publications Ltd: London (14 – 31)

Ehrenreich, B., English, D. (1973) *Witches, Midwives, and Nurses: A History of Women Healers* New York Feminist Press

Elmer, P (2004) *The Healing Arts. Health, Disease and Society in Europe, 1500 – 1800.* Manchester University Press: Manchester

Emerson, R.M., Fretz, R.I., Shaw, L.L. (1995) *Writing Ethnographic Fieldnotes.* University of Chicago Press: Chicago

Evenden, D. (2000) *The Midwives of Seventeenth- Century London.* Cambridge University Press: Cambridge

Fahy, K., Foureur, M., Hastie, C. (2008) *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research.* Elsevier Books for Midwives: London

- Fealy, G. (2005). *Care to remember. Nursing and Midwifery in Ireland.* Mercier Press: Cork
- Fenwick, J., Hammond, A., Raymond, J., Smith, R., Gray, J., Foureur, M., Homer, C., Symon, A. (2012) *Surviving, not Thriving: a qualitative study of newly qualified midwives' experience of their transition to practice.* *Journal of Clinical Nursing*, 21 (13 /14), 2054–2063
- Foley, D., Valenzuela, A. (2008) *Critical Ethnography*, In: Denzin, N., Lincoln, Y. (eds) *The Landscape of Qualitative Research.* Sage Publications Ltd: London (p. 287 – 310)
- Forsey, M. (2010) *Ethnography as Participant Listening.* *Ethnography*, 11 (4), 558 – 572
- Foucault, M. (1973) *The Birth of the Clinic: An Archaeology of Medical Perception.* Routledge: London
- Foucault, M. (1977) *Discipline and Punishment: The birth of the prison.* Allen Lane, Penguin: London
- Foucault, M. (1980) *Power / Knowledge: Selected Interviews and Other Writings 1072 – 1977.* Pantheon Books: New York
- Foucault, M. (1988) *Politics, philosophy, culture: interviews and other writings, 1977-1984.* Routledge: London
- Foucault, M. (1991) *Governmentality*, In: Burchell, G., Gordon, C., Miller, P. (eds) *The Foucault Effect: Studies in Governmentality.* Harvester Wheatsheaf: Hemel, Hempstead (87 – 104)
- Fox, D., Sheehan, A., Homer, C. (2014) *Experiences of Women Planning a Home Birth who Require Intrapartum Transfer to Hospital: A metasynthesis of the qualitative literature.* *International Journal of Childbirth*, 4 (2), 103 – 119
- Fox, N.J. (1999) *Postmodern Reflections on 'Risk', 'Hazards' and Life Choices.* *Risk and Sociocultural Theory: New directions and perspectives.* D. Lupton (ed, 12 – 33), Cambridge University Press: New York
- Fredriksen, S. (2005) *Luck, Risk and Blame.* *Journal of Medicine and Philosophy*, 30(5), 535-553
- Friedson, E. (1986) *Professional Powers: a study of the institutionalisation of formal knowledge.* University of Chicago Press: Chicago
- Garcia, J., Kilpatrick, R., Richards, M. (1990) *The Politics of Maternity Care: Services for Childbearing Women in Twentieth Century Britain.* Clarendon Paperbacks: Oxford

Gau, M.L., Chung, U.L., Kao, C.H., Wu, S.F, Kuo,S.C., Long, A. (2002) A Survey of Obstetricians' Willingness to Practice Collaboratively with Midwives in Taiwan. *Journal of Nursing Research*, 10 (3), 205 - 215

Geertz, C. (1973) *The Interpretation of Cultures: Selected Essays*. Basic Books: New York

Gelis, J. (1991) *History of Childbirth, Fertility, Pregnancy and Birth in Early Modern Europe*. Cambridge University Press: Cambridge

Gergen, K.J., Gergen, M.M. (2008). *Social Construction and Psychological Inquiry*. In: Holstein J, Gubrium J. (Eds.) *Handbook of constructionist research* Sage: Thousand Oaks CA. (p. 171 -189)

Giddens, A. (1991) *Modernity and Self-Identity: Self and Society in the Late Modern Age*. Polity Press: Cambridge

Giddens, A. (1994) *Living in a Post-traditional Society*, In: Beck, U., Giddens, A., Lash, S. (eds) *Reflexive Modernization: Politics, Tradition and Aesthetics in the Modern Social Order*. Polity Press: Cambridge (p. 56 – 109)

Giddens, A. (1998) *Risk Society: the Context of British Politics*, In: Franklin, J. (ed) *The Politics of Risk Society*. Polity Press: Cambridge (23-34)

Gilligan, C. (1982) *In a Different Voice*. Harvard University Press: Cambridge, MA

Gilligan, C. (1987) *Moral Orientation and Moral Development*, In: Feder, E., Meyers, K., Meyers, D. (eds) *Women and Moral Theory*. Rowman & Littlefield: Maryland (p. 19 – 23)

Gilligan, C. (2011) *Joining the Resistance*. Polity Press: Cambridge

Goer, H. (1995) *Obstetric Myths Versus Research Realities: A guide to the medical literature*. Bergin and Garvey: Westport, Connecticut

Goodall, H.L. (2000) *Writing the New Ethnography*. Rowman & Littlefield Publishing Group Inc: Oxford

Government of Ireland (1970) *Health Act*
(<http://www.irishstatutebook.ie/1970/en/act/pub/0001/>)

Government of Ireland. (1998) *Report of the Commission on Nursing – A blueprint for the future*, Government of Ireland: Dublin

Government of Ireland. (2006) *The Lourdes Hospital Inquiry: An Inquiry into peripartum hysterectomy at Our Lady of Lourdes Hospital, Drogheda*. (Author: Judge Harding Clark). Dublin: Stationery Office

- Government of Ireland (2011) Nurses and Midwives Act 2011, Number 41 of 2011. <http://www.nursingboard.ie/en/nurses-midwives-act-2011>, Accessed 26th February 2015
- Grbich, C. (1999) *Qualitative Research in Health. An Introduction*. Sage Publications Ltd: London
- Grbich, C. (2007) *Qualitative Data Analysis. An Introduction*. Sage Publications Ltd: London
- Greten, K.J. (2009) *An Invitation to Social Construction*, 2nd edition. Sage Publications Ltd: London
- Grills, S. (1998) *Doing Ethnographic Research: Fieldwork Settings*. Sage Publications: Thousand Oaks, CA
- Guilliland, K., Pairman, S. (1994) The Midwife Partnership, a Model for Practice. *New Zealand College of Midwives*, 16, 5 - 9
- Haertsh, M., Campbell, E., Sanson-Fisher, R. (1998) Who can Provide Antenatal Care? The view of obstetricians and midwives. *Australian and New Zealand Journal of Public Health*, 22 (4), 471 - 475
- Hammersley, M. (1990) *Reading Ethnographic Research: A Critical Guide*. Longman: London
- Hammersley, M. (1992) *Social Research Philosophy, Politics and Practice*. Sage Publications Ltd: London
- Hammersley, M., Atkinson, P. (1989) *Ethnography: Principles in Practice*, Routledge: London
- Hammersley, M., Atkinson, P. (2007) *Ethnographic Principles in Practice* 3rd edition. The University of Chicago Press: Chicago
- Hannerz, U. (2006) Studying down, up, sideways, through, backwards, forwards, away and at home: Reflections on the field worries of an expansive discipline, In: Coleman, S., Collins, P.J. (eds) *Locating the Field; Space, Place and Context in Anthropology*. Berg: London (p. 23 – 41)
- Harley, D. (1990) Historians as Demonologists: The myth of the midwife-witch. *Social History of Medicine*, 3(1), 1 -26
- Hartz,D.L., Foureur, M., Tracy, S.K. (2012) Australian Case Load Midwifery: the exception or the rule. *Women Birth*, 25, 39–46
- Hastrup, K. (1995) *A Passage through Anthropology: Between Experience and Theory*. Roudledge: London
- Health Services Executive (HSE) (2005) *Maternity Services in the Eastern Area – A strategy for the future 2005 – 2011* HSE: Dublin

- Hedgecoe, A. (2008) Research Ethics Review and the Sociological Research Relationship. *Sociology*, 42 (5), 873 -886
- Higgs, P. (1998) Risk, Governmentality and the Reconceptualisation of Citizenship, In: Scamber, G., Higgs, P. (eds) *Modernity, Medicine and Health*. Routledge: London (176 – 197)
- Hollins-Martin, C., Bull, P. (2005) Measuring Social Influence of a Senior Midwife on Decision-making in Maternity Care: an Experimental Study. *Journal of Community and Applied Social Psychology*, 15 (2), 120 - 126
- Holloway, I., Wheeler, S. (2010) *Qualitative Research in Nursing & Healthcare*, 3rd edition. John Wiley & Sons: West Sussex
- Holy, L. (1984) Theory, Methodology and the Research Process, In: Ellen, R. (ed) *Ethnographic Research: a guide to general conduct*. Academic Press: London
- Horan, A. (2007) Call to Reinstate Home Birth Service. *Galway Independent*, 26th September
- Hunt, S. (2001) *Listening to Women. An ethnography of childbearing women living in poverty*. Unpublished Doctoral Dissertation, University of Warwick
- Hunt, S., Symonds, A. (1995) *The Social meaning of Midwifery*. Macmillan: Basingstoke
- Hunter, B. (2004) Conflicting Ideologies as a Source of Emotion Work in Midwifery. *Midwifery*, 20(3), 261-272
- Hunter, B. (2006) The Importance of Reciprocity in Relationships between Community-based Midwives and Mothers. *Midwifery*, 22(4), 308-322
- Hupcey, J. E., Penrod, J., Morse, J. M., & Mitcham, C. (2001). An Exploration and Advancement of the Concept of Trust. *Journal of Advanced Nursing*, 36 (2), 282-293
- Hutchinson, M., Vickers, M., Jackson, D., Wilkes, L. (2006) Workplace Bulling in Nursing: towards a more Critical Organisational Perspective. *Nursing Inquiry*, 13(2), 118 – 126
- Hyde, A., Roche-Reid, B. (2004). Midwifery Practice and the Crisis of Modernity: Implications for the role of the Midwife. *Social Science and Medicine*, 58, 2613–2623
- Inch, S. (1986) Maternity Services Liaison Committee: An effective initiative for improving the quality of pregnancy care? *Journal of the Royal Society of Medicine*, 79 (4), 242 – 244

Institute of Obstetricians and Gynaecologists (2006) *The Future of Maternity Services and Gynaecological Services in Ireland 2006 -2016* Institute of Obstetricians & Gynaecologists: Dublin

International Confederation of Midwives (2011) *ICM International definition of the Midwife, core document*, ICM: The Netherlands

Janssen, P.A., Saxell, L., Page, L., Klein, M.C., Liston, R.M. (2009) Outcomes of Planned Home Birth with Registered Midwife versus Planned Hospital Birth with Midwife or Physician. *Canadian Medical Association Journal*, 181 (6/7), 377 – 383

Johnson, K.C., Daviss, B.A. (2005) Outcomes of Planned Home Births with Certified Professional Midwives: large prospective study in North America. *British Medical Journal* 330 (7505), 1416

Johnstone, R.W. (1952) *William Smellie, the Master of British Midwifery*. Livingstone: London

Jomeen, J. (2007) Choice in Childbirth: A realistic expectation? *British Journal of Midwifery*, 15(8), 485 -489

Jomeen, J. (2010) *Choice, Control and Contemporary Childbirth*. Radcliffe Publishing: Buckinghamshire

Jordan, B. (1993) *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States*. Waveland Press: Illinois

Jouhki, M.R. (2012) Choosing Home Birth – The women's perspective. *Women and Birth* 25, e56 – e61

Kalisch, B.J., Kalisch, P.A., Scobey, M. (2004) Emergence of Modern Midwifery, In: van Teijlingen, E., Lewis, G., McCaffery, P. (eds) *Midwifery and the medicalisation of childbirth: Comparative perspectives*. Nova Science: Happaage, New York

Katz Rothman, B. (1991) *In Labour: Women and Power in the Birthplace*. W.W. Norton & Co Inc: New York

Kavanagh, R. (2005). *Mamie Cadden: Backstreet Abortionist*. Mercier Press: Cork

Keating, A., Fleming, V.E.M. (2009) Midwives' Experiences of Facilitating Normal Birth in an Obstetric-led unit: a feminist perspective. *Midwifery*, 25, 518–527

Keirse, M.J. (2010) Home Birth: gone away, gone astray, and here to stay. *Birth* 37 (4), 341 – 346

Kennedy, F. (2001) *Cottage to Crèche: Family change in Ireland*, Dublin Institute of Public Administration

- Kennedy, P. (2002) *Maternity in Ireland. A woman centred perspective* The Liffey Press: Dublin
- Kennedy, P. (2004) *Childbirth in Ireland* In: Kennedy, P. (ed.) *Motherhood in Ireland: Creation and Context*. Mercier Press: Dublin
- Kennedy, P., Murphy-Lawless, J. (1998) *Returning Birth to Women: Challenging Policies and Practices*. CWS, TCD, WERRC, UCD: Dublin
- Kincheloe, J. L., McLaren, P. (2005). *Rethinking critical theory and qualitative research*, In: Y. S. Lincoln and N. K. Denzin (Eds.) *The Sage Handbook of Qualitative Research*, 3rd edition. Sage Publications Ltd: London (p.303-342)
- Kinder, P., 2001. *Report of the Maternity Services Review Group*. North Eastern Health Board: Kells
- King, H. (2007) *Midwifery, Obstetrics and the Rise of Gynaecology: The uses and rise of sixteenth-century compendium*, Ashgate Publications: Aldershot, Hants
- Kirkham M. (1996) *Supervision of Midwives*. Books for Midwives Press: Hale
- Kirkham, M. (2000) *The Midwife-Mother Relationship*. Palgrave Macmillan: Hampshire
- Kirkham, M. (2010) *The Maternity Services Context*. In M. Kirkham (Ed.), *The midwife–mother relationship* (2nd ed. 1–16). Palgrave Macmillan: Basingstoke Hants, England
- Kirkham, M. (2011) *A Duty of Obedience or Duty of Care?* AIMS Journal, 23(3) <http://www.aims.org.uk/Journal/Vol23No3/dutyOfCare.htm> Accessed 21st February 2015
- Kirkham, M., Davies, S., Edwards, N., Murphy-Lawless, J. (2012) *Midwives and Human Rights*. MIDIRS Midwifery Digest 22 (4), 441-498
- Kirkham, M., Morgan, R.K., Davies, A. (2006) *Why Midwives Stay*. Department of Health: London www.nhsemployers.org www.rcm.org
- Kirkham, M., Stapleton, H., Curtis, P., Thomas, G. (2002) *Stereotyping as a Professional Defence Mechanism*. *British Journal of Midwifery*, 10 (9), 549-552
- Kirkham, M., Stapleton, H. (2004) *The Culture of the Maternity Services*, In: Kirkham, M. (ed) *Informed Choice in Maternity Care*. Palgrave MacMillan: Basingstoke

- Kitzinger, S. (2000) Forward In: Page, L.A., Percival, P. (eds) *The New Midwifery: Science and Sensitivity in Practice*. Churchill Livingstone, Elsevier: The Netherlands (p. ix)
- Kontoyannis, M., Katsetos, C. (2008) What Influences Women in Athens to Choose Home Birth? *British Journal of Midwifery*, 16 (1), 44 -48
- KPMG (2008) *Independent Review of Maternity and Gynaecology Services in the Greater Dublin Area, Final Report KPMG: Dublin*
- Lane, K. (1995) The Medical Model of the Body as a Site of Risk: A case study of childbirth, In: Gabe, J. (ed) *Medicine, Health and Risk – Sociological Approaches*. Blackwell: Oxford (p. 53 – 72)
- Lane, K. (2002) Midwifery: a Profession in Transition. *Australian Journal of Midwifery*, 15(2), 26 – 31
- Lane, K. (2012) Dreaming the Impossible Dream: ordering risks in Australian maternity care policies, *Health Sociology Review*. 21 (1), 23 – 35
- Lane, K., Reiger, K. (2013) Regime Change in Australian Maternity Hospitals, *Social Theory & Health*, 11 (4), 407 – 427
- Langton, P. (1994) Competing Occupational Ideologies, Identities and the Practice of Nurse-Midwifery, In: Levy, J. (ed) *Current Research on Occupations and Professions*. JAI Press: Greenwich CT (p. 149 – 177)
- Lankshear, G., Ettore, E., Mason, D. (2005) Decision-making, Uncertainty and Risk: Exploring the complexity of work processes in NHS delivery suites. *Health, Risk & Society*, 7 (4), 361 - 377
- Leahy, A.L., and Wiley, M. (1998) *The Irish health System in the 21st century*. Oak Tree Press: Dublin.
- Leap, N. Hunter, B. (1993) *The Midwife's Tale: An oral history from handywoman to professional midwife*. Scarlet Press: London
- LeCompte, M.D., Schensul J. (2010) *Designing and Conducting Ethnographic Research*. The Rowman & Littlefield Publishing Group Inc: Plymouth, UK
- Levy, V. (2004) How Midwives use Protective Steering to Facilitate Informed Choice in Pregnancy. In: *Informed Choice in Maternity Care*, Kirkham M. (ed), MacMillan Press: London
- Lincoln, Y.S., Guba, E. (1985) *Naturalistic Inquiry*. Sage Publications: Thousand Oaks, CA
- Lindemann, M. (2010) *Medicine and Society in Early Modern Europe* 2nd edition. Cambridge University : Cambridge

- Lindgren, H., Erlandsson, K. (2010) Women's Experiences of Empowerment in a Planned Home Birth: a Swedish population-based study *Birth* 37, 309 – 317
- Lindgren, H. E., Hildingsson, I.M., Christensson, M., Rådestad I.J. (2008a). Transfers in Planned Home Births Related to Midwife Availability and Continuity: a nationwide population-based study. *Birth* 35 (1), 9-15.
- Lindgren, H., Rådestad, I., Christensson, K., Hildingsson, I. (2008b) Outcome of Planned Home Births in Sweden 1992 – 2005. *Acta Obstetrica et Gynecologica*, 87 (7), 751 – 759
- Lindgren, H., Rådestad, I., Christensson, K., Wally-Bystrom, K., Hildingsson, I.M. (2010) Perceptions of Risk and Risk Management Among 737 Women who opted for Home Birth. *Midwifery* 26(2), 163 – 172
- Lindgren, H., Rådestad, I., Hildingsson, I.M. (2011) Transfer in planned home births in Sweden – Effects on the experience of birth: A nationwide population-based study. *Sexual and Reproductive Healthcare: Official Journal of the Swedish Association of Midwives* 2(3), 101-105
- Lindsey, P. (2006) Creating Normality in a high-risk Pregnancy. *The Practising Midwife*, 9 (1), 16 - 19
- Lipson, J. (1991) The use of self in Ethnographic Research, In: Morse, J.M. (ed.) *Critical issues in qualitative research methods*. Sage Publications Ltd: London (p. 73-9)
- Lokugamage, A. (2011) Fear of Home Birth in Doctors and Obstetric Iatrogenesis. *International Journal of Childbirth*, 1(4), 263-272
- Lothian, J. (2013) Being Safe: Making the Decision to have a Planned Home Birth in the United States. *The Journal of Clinical Ethics*, 24 (3), 266 – 275
- Loudon, I. (2008) General Practitioners and Obstetrics: a brief history. *Journal of the Royal Society of Medicine*, 101 (11), 531 – 535
- Lowis, G., McCaffery, P. (2004) Sociological factors affecting the medicalisation of midwifery. In: van Teijlingen, E. (ed) *Midwifery and the medicalisation of childbirth: comparative perspectives*. Nova Science Publications: New York (p. 5-41)
- Luddy, M. (2011) 'Unmarried Mothers in Ireland, 1880-1973', *Women's History Review*, 20 (1), 109–26
- Luhmann, N. (1979) *Trust and Power*. Wiley: Chichester
- Luhmann, N. (1988) *Trust: Making and Breaking Cooperative Relations*, In: Gambetta, D. (ed) *Familiarity, Confidence, Trust: Problems and Alternatives*. Blackwell: London (94 – 107)

- Luhmann, N. (1990) The Paradox of System Differentiation and the Evolution of Society, In: Alexander, J., Colomy, P. (eds) *Differentiation Theory and Social Change*. Columbia University Press: New York (p. 409 – 440)
- Lupton, D. (1999) *Risk and Sociocultural Theory. New directions and perspectives*. Cambridge University Press: Cambridge
- Lupton, D. (2013) *Risk*, 2nd edition. Routledge: London
- Lupton, D., Tulloch, J. (2002) ‘Risk is Part of your Life’: risk epistemologies among a group of Australians. *Health, Risk & Society*, 4 (2), 113 -124
- Maher, J. (2003) Rethinking Women’s Birth Experiences: Medical frameworks and personal narratives. *Hecate*, 29, 140 -152
- Mander, R. (2001) *Supportive Care in Midwifery*. Blackwell Science: Oxford
- Mander, R. (2004) *Men and Maternity*. Routledge: London
- Mander, R., Murphy-Lawless, J. (2013) *The Politics of Maternity*. Routledge: London
- Marcus, G.E. (1995) Ethnography in/ of the World System: The Emergence of Multi-Sited Ethnography. *Annual Review of Anthropology*, 24, 95 – 117
- Marland, H. (1993) *The art of Midwifery: Early modern midwives in Europe*. Routledge: London
- Marland, H., Rafferty, A. (1997). *Midwives, Society, and Childbirth: Debates and Controversies in Modern Period*. Routledge: London
- Martin, E. (1987) *The Woman in the Body: A cultural analysis of reproduction*. Beacon Press: Boston
- Matthews A. (2006) *Past and Present, Power and Empowerment in Midwifery in Ireland*. Unpublished Doctoral Dissertation, Dublin City University: Dublin
- Mauthner, N., Doucet, A. (1998) Reflections on a Voice Centred Relational Method of Data Analysis: analysing maternal and domestic voices, In: Ribbens, J., Edwards, R. (eds) *Feminist Dilemmas in Qualitative Research: Private Lives and Public Texts*. Sage Publications Ltd: London (p. 119-144)
- Maxwell, J.A. (2012) *A Realist Approach for Qualitative Research*. Sage Publications Ltd: London
- McCourt, C. (2009) How Long Have I Got? Time in labour: Themes from women’s birth stories, In: McCourt, C. (ed) *Childbirth, Midwifery and Concepts of Time*. Berghahn Books: Oxford (p. 184 -201)

McCourt, C., Dykes, F. (2009) From Tradition to Modernity: Time and childbirth in historical perspective. In: McCourt, C. (ed) Childbirth, midwifery and concepts of time. Berghahn Books: Oxford (p. 17 -36)

McCourt, C., Rayment, J., Rance, S., Sandall, J. (2012) Organisational Strategies and Midwives' Readiness to Provide Care for out of Hospital Births: An analysis for the Birthplace organisational case studies. *Midwifery*, 28(5), 636 – 645

McGreevy, R. (2013) Woman loses legal challenge to home birth ruling University lecturer sought orders compelling HSE to allow her have baby at home. *Irish Times*, 16th August <http://www.irishtimes.com/news/crime-and-law/courts/woman-loses-legal-challenge-to-home-birth-ruling>
[1.1496170](http://www.irishtimes.com/news/crime-and-law/courts/woman-loses-legal-challenge-to-home-birth-ruling)

McGreevy, R. (2014) Home birth advocates to protest over midwife insurance. *The Irish Times*, 5th October <http://www.irishtimes.com/news/ireland/irish-news/home-birth-advocates-to-protest-over-midwife-insurance-1.1952601>

McIntosh, T. (1998) Professional Skill or Domestic Duty? Midwifery in Sheffield 1881 – 1936. *Social History of Medicine*, 11 (3), 403 – 420

McIntosh, T. (2012) *A Social History of Maternity and Childbirth. Key themes in maternity care.* Routledge: London

McIntosh, T. (2013) *Changing Childbirth: Consigned to the 'Shelf of History;'*? *MIDIRS Midwifery Digest* 23(4), 415 – 420

McKinlay, J.B. (1981) From 'Promising Report' to 'Standard Procedure': Seven stages in the career of medical innovation. *The Milbank Memorial Fund Quarterly*, 59 (3), 374 - 411

McMahon, A. (2000) *The Regulation of Midwives with Special Reference to Aspects of the Regulation of Midwives in Ireland 1918-1950.* Unpublished MA Dissertation. University College Dublin: Dublin

McMahon, A. 2005. *Regulating Midwives: The role of the RCPI*, In: Fealy, G. (ed.) *Care to Remember. Nursing and Midwifery in Ireland.* Mercier Press: Cork

Meaney S, Sweeney S, Delaney J, Corcoran P, Greene RA, Sugrue S. (2013) *Planned Home Births in Ireland Annual Report 2012; HSE National Home Birth Service provided by Self Employed Community Midwives.* Health Service Executive: Cork

Meyer, S., Ward, P., Coveney, J., Rogers, W. (2008) Trust in the Health System: An analysis and extension of the social theories of Giddens and Luhmann. *Health Sociology Review*, 17, 177 – 186

- Millar, M. (2003) Institutionalism 'Old' and 'New', In M. Adshead & M. Millar (Eds.) *Public Administration and Public Policy in Ireland: Theory and Methods*, Routledge: London
- Millar, S. (2009) The Memorandum of Understanding (MOU) – implications Annual All Ireland North South (INMO/RCM) Midwifery Conference, October
- Millar, S., Daly, D., Ní Mhurchú, P. (2008) Home Birth in Ireland. *Changing Times The Practising Midwife* 1, (10): 15 – 17
- Minkowski, W.L. (1992) Women Healers of the Middle Ages: Selected Aspects of their History. *American Journal of Public Health*, 82 (2), 228 - 295
- Monaghan, L.F., O'Dwyer, M., Gabe, J. (2013) Seeing University Ethics Committee Approval: The Emotional Vicissitudes of a "Rationalised" Process. *International Journal of Social Research Methodology*, 16 (1), 65 – 80
- Morison, S., Hauck, Y., Percival, P., McMurray, A. (1998) Constructing a Home Birth Environment through Assuming Control. *Midwifery* 14, 233 – 241
- Moses, J., Knutsen, T. (2012) *Ways of Knowing. Competing Methodologies in Social and Political Research*, 2nd edition. Palgrave Macmillan: Basingstoke, Hampshire
- Murphy-Lawless, J. (1991) Piggy in the middle: the midwife's role in achieving woman controlled childbirth. *The Irish Journal of Psychology*, 12 (2), 198-215
- Murphy-Lawless, J. (1998) *Reading Birth and Death. A history of obstetric thinking*. Cork University Press: Cork
- Murphy-Lawless, J. (2011) 'Ceiling Caves In': Current state of maternity services in Ireland, *MIDIRS Midwifery Digest*, 21 (4), 446 – 451
- Murphy-Lawless, J. (2012) Empty promises: the dangers of risk discourses. In Hayes-Klein, H. (ed) *Conference Papers, Human Rights in Childbirth. International Conference of Jurists, Midwives and Obstetricians*. (pg 68 – 73). Bynkershoek Publishing: The Hague, Netherlands
- National Institute for Health and Care Excellence (NICE) (2014) *Intrapartum Care: care of healthy women and their babies during childbirth*. NICE: UK
- Newnham, E., Pincombe, J., McKellar, L. (2013) Access or Egress? Questioning the "ethics" of ethics committee review for an ethnographic doctoral research study in a childbirth setting. *International Journal of Doctoral Studies*, 8, 121 – 136

- Oakely A. (1976) *Wise Woman and Medicine Man: changes in the management of childbirth*, In: Oakely, A., Mitchell, J. (eds) *The Rights and Wrongs of Women*. Penguin: Harmonds-Worth
- Oakley, A. (1981) *Interviewing Women: a contradiction in terms*, In: Roberts, H. (ed) *Doing Feminist Research*. Routledge: London
- Oakley, A. (1984) *The Captured Womb: A history of the medical care of pregnant women*. Blackwell: Oxford
- Oakley, A. (1993). *Essays on Women, Medicine and Health*. Edinburgh University Press: Edinburgh
- Oakley, A. (2000) *Experiments in Knowing: Gender and Method in Social Sciences*. Polity Press: Cambridge
- OBoyle, C. (2009) *An Ethnography of Independent Midwifery in Ireland*, Unpublished PhD thesis, Trinity College Dublin
- OBoyle, C. (2010) Letter to the Editor – Choosing Home Birth, *The Irish Times* 26th November
- OBoyle, C. (2013) ‘Just Waiting to be Hauled over the Coals’: Home birth midwifery in Ireland. *Midwifery* 29 (8), 998 - 995
- O’Connell, R. (2011) *The Size Paradox: The mega-maternity unit as a vector for authentic midwifery to emerge*. Unpublished PhD Thesis: University of Central Lancashire
- O’Connell, R., Downe, S. (2009). A Metasynthesis of Midwives' Experience of Hospital Practice in Publicly Funded Settings: compliance, resistance and authenticity. *Health: An interdisciplinary journal for the social study of health, illness and medicine*, 13(6), 589–609
- O’Connor, M. (1992) *Women and Birth: A national study of intentional home births in Ireland*, study conducted under the aegis of the Coombe Lying in Hospital and the Department of Health, unpublished.
- O’Connor, M. (1995) *Birth Tides*, Pandora: London
- O’Connor, M. (2011) *Bodily Harm. Symphysiotomy and Pubiotomy in Ireland, 1944 – 1992*. Everytype: Cathair na Mart
- O’Driscoll K, Meagher D, Robson M. (2003) *Active Management of Labour: the Dublin experience* 4th Edition. Mosby: Edinburgh.
- O’Dwyer, I. and Mulhall, A. (2000) *Midwifery In: Robins, J. (ed.) Nursing and midwifery in Ireland in the twentieth century*. An Bord Altranais: Dublin

- Ólafsdóttir, Ó.Á. A. (2006) An Icelandic Midwifery Saga - Coming to Light. "With Woman" and Connective Ways of Knowing. Unpublished PhD Thesis, Thames Valley University
- Ólafsdóttir, Ó.Á., Kirkham, M. (2009) Narrative Time: Stories, Childbirth and Midwifery, In: McCourt, C. (ed) *Childbirth, Midwifery and Concepts of Time*. Berghahn Books: Oxford (p. 167 – 183)
- Olsen, O., Clausen, J.A. (2012) Planning Hospital Birth versus Planning Home Birth (Review). The Cochrane Collaboration, Cochrane Database Systematic Review.12;9:CD000352. doi: 10.1002/14651858.CD000352.pub2
- O'Malley, S. (2002) *Midwifery Led Maternity Services: The role of supervision in ensuring quality care*. Unpublished MSc Dissertation, Trinity College Dublin: Dublin
- O'Reilly, K. (2009) *Key Concepts in Ethnography*. Sage Publications Ltd: London
- Page, L. (2008) Being a Midwife to Midwifery: transforming midwifery services, In: Fahy, K., Foureur, M., Hastie, C. (eds) *Birth Territory and Midwifery Guardianship: Theory for Practice, Education and Research*. Elsevier Books for Midwives: London (p. 115 – 129)
- Pairman S, McAra-Couper J. (2006) Theoretical Frameworks for Midwifery Practice, In: Pairman, S., Thorogood, C., Tracey, S. (eds) *Midwifery: preparation for practice*, Elsevier Churchill Livingstone: Sydney
- Parker, M. (2007) Ethnography / Ethics. *Social Science and Medicine*, 65 (11), 2248 – 2259
- Parsons, M., Griffiths, R. (2007) The Effect of Professional Socialisation on Midwives' Practice. *Women and Birth*, 20 (1), 31 - 34
- Peel Committee Standing Maternity and Midwifery Advisory Committee (Peel Report) (1970) *Domiciliary Midwifery and Maternity bed needs*. HMSO: London
- Percival, R. (1970) Management of Normal Labour. *Practitioner*, 1221, 204
- Pink, S. (2009) *Doing Sensory Ethnography*. Sage Publications Ltd: London
- Pink, S. (2013) *Doing Visual Ethnography*. Sage Publications Ltd: London
- Porter, R., Wear, A. (1987) *Problems and Methods in the History of Medicine*. Croom Helm: London
- Rees, C., Gatenby, M. (2014) Critical Realism and Ethnography, In: Edwards, P.K., O'Mahoney, J., Vincent, S. (eds) *Studing Organizations Using Critical Realism*. Oxford University Press: Oxford (132 -147)

- Riebel, T. (2004) Normal Birth: A thing of the past or the new future for primary care. *Primary Health Care Research and Development*, 5, 329 - 337
- Reiger, K. (2006) 'The Neoliberal Quickstep: Contradictions in Australian maternity care policy', *Health Sociology Review*, Special Issue, *Childbirth, Politics and the Culture of Risk* 15 (4), 330-340
- Robben, A. (2007) Multi-sited Fieldwork. Introduction, In: Robben, A., Slyka, J. (eds) *Ethnographic Fieldwork: An Anthropological Reader*, 2nd edition. Wiley-Blackwell: Oxford (p.331- 336)
- Robins J. (2000) *Nursing and Midwifery in Ireland in Twentieth Century An Bord Altranais: Dublin*
- Robinson, S. (1990) Maintaining the independence of the midwifery profession: a continuing struggle, In: Garcia, J., Kilpatrick, R., Richards, M. (eds) *The politics of maternity care: Services for childbearing women in 20th century Britain*. Clarendon: Oxford (p. 61 -91)
- Robinson, S., Thomson, A.M. (1994) *Midwives, Research and Childbirth (vol 2)* Chapman and Hall: London
- Rolfe, G. (2006) Validity, Trustworthiness and Rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing*, 53 (3), 304 - 310
- Rowley, E. (2010) Naughty Knickers, Stick-on Nipples and Mrs Doubtfire: The 'humorous' talk of post-mastectomy women, In: Hillyard, S. (ed) *New Frontiers in Ethnography (Studies in Qualitative Methodology Vol. 11)*. Emerald Group Publishing Ltd: Bingley, UK (125 – 140)
- Sandall, J. (1997) *Midwives Burnout and Continuity of Care*. *British Journal of Midwifery*, 5 (1), 106-111
- Sandall, J., Soltani, H., Gates, S., Shennan, A., Devane, D. (2013) *Midwife-led Continuity Models versus Other Models of Care for Childbearing Women*. *Cochrane Database of Systematic Reviews*, Issue 8. Art. No.: CD004667. DOI: 10.1002/14651858.CD004667.pub3
- Sargent, L. (2002) Practice and Autonomy, In: Mander, R., Fleming, V. (eds) *Failure to progress: The contraction of the midwifery profession*, Routledge: London (p. 39 – 62)
- Savage, J. (2006) *Ethnographic Evidence. The value of applied ethnography in healthcare*. *Journal of Research in Nursing*, 11 (5), 383 – 393
- Scamell, M., Alaszewski, A. (2012) *Fateful Moments and the Categorisation of Risk: Midwifery practice and the ever-narrowing window of normality during childbirth*. *Health Risk and Society*, 14 (2), 207 – 211
- Scheff, T.J. (2000) *Shame and the Social Bond: A sociological theory*. *Sociological Theory*, 18 (1), 84 -99

- Schiebinger, L. (2000) Skeletons in the Closet: The first illustrations of the female skeleton in eighteenth-century anatomy In: Schiebinger, L. (ed) *Feminism and the Body*, University Press: Oxford (p. 25 – 57)
- Schwandt, T.A. (2003) Three Epistemological Stances for Qualitative Inquiry: Interpretivism, Hermeneutics and Social Constructionism. In: Denzin, N., Lincoln, Y. (eds) *The Landscape of Qualitative Research: Theories and Issues*. Sage: Thousand Oaks, CA (p. 229 – 331)
- Scott Jones, J. (2010) Thinking through Ethnography. An Introduction, In: Scott Jones, J., Watt, S. *Ethnography in Social Science Practice*, Routledge Taylor and Francis Group: London Chapter 1.
- Seibold, C., Licqurish, S., Rolls, C., Hopkins, F. (2010) 'Lending the Space'. Midwives perceptions of birth space and clinical risk management. *Midwifery* 26 (5), 526 - 531
- Shelton, D.C. (2012) Man-midwifery History: 1730 – 1930. *Journal of Obstetrics and Gynaecology*, 32, 718 - 723
- Shiel, T. (2013a) Inquest told home birth abandoned after problems. Mother rushed to Mayo General Hospital after baby's heartbeat changed. *The Irish Times*, 10th September <http://www.irishtimes.com/news/crime-and-law/inquest-told-home-birth-abandoned-after-problems-1.1521423>
- Shiel, T. (2013b) Midwives should not deal with home births alone, coroner says. Mayo inquest finds stillborn infant died by misadventure. *The Irish Times*, 10th September <http://www.irishtimes.com/news/crime-and-law/midwives-should-not-deal-with-home-births-alone-coroner-says-1.1522334>
- Siggins, L. (2003) Minister seeks report on decision to suspend home births scheme. *Irish Times* 4th April
- Silverman, D. (2010) *Doing Qualitative Research*, 4th edition. Sage Publications Ltd: London
- Simonds, W, Rothman, B., Norman B. (2007) *Labouring on: Birth in transition in the United States*. Routledge: New York
- Singer, M. (1995). Beyond the Ivory Tower: Critical praxis in medical anthropology. *Medical Anthropology Quarterly*, 9(1), 80-106
- Sjöblom, I., Nordström, B., Edberg, A.K. (2006) A Qualitative study of Women's Experience of Home Birth in Sweden. *Midwifery*, 22, 348 – 355
- Skeggs, B. (2001) Feminist Ethnography, In: Atkinson, P., Coffey, A., Delamont, S., Lofland, J., Lofland, L. (eds) *Handbook of Ethnography*. Sage Publications Ltd: London (p. 426 – 443)
- Smith, V., Devane, D., Murphy-Lawless, J. (2012) Risk in Maternity Care: A Concept Analysis. *International Journal of Childbirth*, 2 (2), 126-13

Sommers, S. (2011) Transcending the Sexed Body: Reason, sympathy and 'thinking machines' in the debates over male midwifery, In: Mangham, A., Depledge, G. (eds) *The female body in medicine and literature*. University of Liverpool Press: Liverpool

Stapleton, H., Kirkham, M., Curtis, P., Thomas, G. (2002) Silence and Time in Antenatal Care. *British Journal of Midwifery*, 10 (6), 393 – 396

Stephens, L. (2005) Worrying truth behind home birth figures (editorial). *British Journal of Midwifery* 13(1), 4-5

Stevens, T. (2009) Time and Midwifery Practice, In: McCourt, C. (ed) *Childbirth, Midwifery and Concepts of Time*. Berghahn Books: Oxford (p. 104 – 125)

Stewart, M. (2008) *Midwives' Discourse on Vaginal Examination during Labour*. Unpublished Doctoral Dissertation, University of the West of England, Bristol

Summers, A. (1989) The Mysterious Demise of Sarah Gamp: The Domiciliary Nurse and Her Detractors, c. 1830-1860 *Victorian Studies*, 32(3): 365 – 386

Symon, A. (2011) The Irish Nurses and Midwives Bill: Legal Charges and Challenges *British Journal of Midwifery* 19 (3), 193 – 194

Symon, A., Paul, J., Butchart, M., Carr, V., Dugard, P. (2008) Maternity Unit Design (Part3): environment, comfort and space. *British Journal of Midwifery*, 16 (3), 167 – 171

Symonds, A., Hunt, S. (1996) *The Midwife and Society: Perspectives, policies and practice*. Macmillan: Basingstoke

Tedlock, B. (2000) Ethnography and Ethnographic Representation, In: Denzin, N., Lincoln, Y. (eds) *Handbook of Qualitative Research*. Sage Publications Ltd: London (p. 455 – 486)

Teehan, A. (2013a) To all those who do not understand, I will defend you. Aja Teehan's Blog, 4th August. <http://www.ajateehan.com/2013/08/to-all-those-who-do-not-understand-i-will-fight-for-you-anyway/> (Accessed February 2015)

Teehan, A. (2013b) It's a boy! Aja Teehan's Blog, 17th November. <http://www.ajateehan.com/2013/11/its-a-boy/> (Accessed February 2015)

Tew, M. (1995) *Safer Childbirth? A critical history of maternity care*: Chapman and Hall: London

Tew, M. (1998) *Safer Childbirth ?: A critical history of Maternity Care*, 3rd edition. Free Association Books: London

- Thomas, J. (1993) *Doing Critical Ethnography*. Sage Publications Ltd: London
- Thompson, S. (2007) Women face 'Conveyor Belt' during Childbirth. *The Irish Times*, 1st May
- Tobin, G., Begley, C.M. (2004) Methodological Rigour within a Qualitative Framework. *Journal of Advanced Nursing*, 84 (4), 388 – 396
- Torres, J., de Vries, R.G (2009) Birthing Ethics: What mothers, families, childbirth educators, nurses and physicians should know about the ethics of childbirth. *Journal of Perinatal Education*, 18(2), 12 -24
- Tracy, S.K., Hartz, D.L., Tracy, M.B., Allen, J., Forti, A., Hall, B., White, J., Lainchbury, A., Stapleton, H., Beckmann, M., Bisits, A., Homer, Foureur, M., Welsh, A., Kildea, S.(2013) Case load midwifery care versus standard maternity care for women of any risk: M@NGO, a randomised controlled trial. *Lancet*, 382(9906), 1723–1732
- Tuchman, A.M. (2005) 'The True Assistant to the Obstetrician': State regulation and the legal protection of midwives in nineteenth-century Prussia. *Social History of Medicine*, 18 (1), 23 – 38
- Turner, B.S. (1995) *Medical Power and Social Knowledge*. Sage Publications Ltd: London
- Turner, C., Hodge, M. N. (1970) *Occupations and Professions In: Jackson, J. A. (ed.) Professions and Professionalization*, Cambridge University Press: Cambridge
- van Maanen, J. (2011) *Tales of the Field: On Writing Ethnography*, 2nd edition. University Of Chicago Press: Chicago
- van Teijlingen, E. (2005) A Critical Analysis of the Medical Model as used in the Study of Pregnancy and Childbirth. *Sociological Research Online*, 10 (2) <http://www.medicalsociologyonline.org> Accessed 3rd August 2014.
- van Teijlingen, E., Lowis, G., McCaffery, P. (2004) *Midwifery and the Medicalisation of Childbirth: Comparative perspectives*. Nova Science: Happaug, New York
- Viisainen, K. (2001) Negotiating Control and Meaning: Home birth as a self-constructed choice in Finland. *Social Science & Medicine* 52, 1109 – 1121
- Wagner, M. (1994) *Pursuing the Birth Machine: The search for appropriate birth technology*, Ace Graphics: Seven Oaks, Kent
- Wagner, M. (2001) Fish can't see Water: The need to humanise birth. *Journal of Gynaecology and Obstetrics*, 75, S25 – S37

- Walsh, D. (1999) An Ethnographic Study of Women's Experience of Partnership Caseload Midwifery Practice: The professional friend. *Midwifery*, 15 (3), 165-176
- Walsh, D. (2004) 'Becoming Mother': An ethnography of a free standing birth centre. Unpublished Doctoral Dissertation: University of Central Lancashire
- Walsh, D. (2006). Subverting the Assembly-line: Childbirth in a free-standing birth centre. *Social Science and Medicine*, 62, 1330–1340
- Walsh, D. (2007) *Improving the Maternity Services. Small is Beautiful-Lessons from a Birth Centre*, Radcliffe Publishing: Oxford
- Walsh, D. (2010) 'Waiting on Birth': Management of Time and Place in a birth centre. In McCourt, C. (ed) *Childbirth, Midwifery and Concepts of Time*. Berghahn Books: Oxford (p. 126-144)
- Walsh, D., Devane, D. (2012) A Metasynthesis of Midwife-Led Care *Qualitative Health Research*, 22(7), 897–910
- Walsh, D., Evans, K. (2014) Critical Realism: An important theoretical perspective for midwifery research. *Midwifery*, 30 (1), e1 –e6
- Walsh, O. (2013) *Report on Symphysiotomy in Ireland 1944 – 1984*. Department of Health, Ireland
- Wasserfall, R.R. (1997) Reflexivity, Feminism and Difference, In: Hertz, R. (ed) *Reflexivity and Voice*. Sage: Thousand Oaks, California
- Watson, T.J. (2012) Making Organisational Ethnography. *Journal of Organisational Ethnography*, 1, 15 -22
- Wendland, C.L., (2013) Exceptional Deliveries: Home births as ethical anomalies in American obstetrics. *The Journal of Clinical Ethics*, 24 (3), 253 – 265
- Wiegers, T.A., van der Zee, J., Keirse, M.J.C (1998) Transfer from Home to Hospital: What is its effect on the experience of childbirth? *Birth*, 25 (1), 19 - 24
- Wiegers, T.A., Keirse, M.J.N.C, van der Zee, J., Berghs, G.A.H. (1996) Outcome of Planned Home Birth and Planned Hospital Births in low risk Pregnancies: Prospective study in midwifery practice in the Netherlands. *British Medical Journal*, 313, 1309 - 1313
- Willis, E. (1983) *Medical Dominance: The division of care in Australian Healthcare*. Allen & Unwin: Sydney
- Willis, E. (2006) *Medical Dominance Revised*. Allen & Unwin: Sydney

Wilson, A. (1995) *The Making of Man-midwifery: Childbirth in England 1660 – 1770*. Harvard University Press: Cambridge, MA

Wilyman-Bugter, M., Lackey, T. (2013) Midwives' Experiences of Home Birth Transfer. *Evidence Based Midwifery*, 11 (1), 28 - 34

Witz, A. (1992) *Professions and Patriarchy*. Routledge: London

Woodcock, C. (2005) The Silenced Voice in Literacy: Listening beyond words to a 'struggling' adolescent girl. *Journal of Authentic Learning*, 2 (1), 47 – 60

Wren, M.A. (2003) *Unhealthy State: Anatomy of a sick society* New Island Dublin, New

COURT CASES

O'Brien versus South Western Health Board, Brannick versus East Coast Area Health Board, Clarke versus South Western Area Health Board, Lockhart versus South Western Area Health Board [2003]

<http://www.supremecourt.ie/Judgements.nsf/1b0757edc371032e802572ea0061450e/c8e6d502f9c0512d80256def00518e49?OpenDocument>

Teehan versus the Health Service Executive and the Minister for Health [2013] IEHC 383

(Courts.ie Accessed on February 2015)